

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: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 1/7/2021 8:31 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/7/2021	Time: 8:31 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HAMILTON MEMORIAL HOSPITAL (14-1326) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) VICTORIA WOODROW
Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	32,441	293,332	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	14,951	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		4,474		0	10.00
10.01	RURAL HEALTH CLINIC II	0		9,825		0	10.01
200.00	Total	0	47,392	307,631	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: 14-1326		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/7/2021 8:31 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 611 SOUTH MARSHALL			PO Box:				1.00		
2.00	City: MCLEANSBORO			State: IL		Zip Code: 62859		County: HAMILTON		
		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		HAMILTON MEMORIAL HOSPITAL	141326	99914	1	05/01/2003	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HAMILTON MEMORIAL HOSP SWING BED	14Z326	99914		05/01/2003	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		HAMILTON MEMORIAL FAMILY CLINIC	143477	99914		01/11/2006	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		HAMILTON MEMORIAL FAMILY CLINIC NC	148529	99914		05/06/2013	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020		20.00
21.00	Type of Control (see instructions)						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: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
1/7/2021 8:31 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1326		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/7/2021 8:31 am			
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code					
		1.00	2.00	3.00					
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00		
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
		1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
						1.00			
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)									
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
		1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
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Date/Time Prepared:
1/7/2021 8:31 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
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	
70.00	Inpatient Psychiatric Facility PPS					
	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: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/7/2021 8:31 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/7/2021 8:31 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	48,483	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: 14-1326		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/7/2021 8:31 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	Y	Y	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	157.00			
158.00	SUBPROVIDER					158.00			
159.00	SNF	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00			
161.00	CMHC		N	N	N	161.00			
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							N	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		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 1/7/2021 8:31 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/13/2020	Y 11/13/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 1/7/2021 8:31 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/7/2021 8:31 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/7/2021 8:31 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	20,904.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	20,904.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	20,904.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/7/2021 8:31 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	659	71	871			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	2,076	0	2,320			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	135			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,735	71	3,326			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)	2,735	71	3,326	0.00	113.46	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,206	0	9,248	0.00	11.06	26.00
26.01	RURAL HEALTH CLINIC II	204	0	4,102	0.00	6.18	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	130.70	27.00
28.00	Observation Bed Days		0	176			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/7/2021 8:31 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	234	33	332	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	234	33	332	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1326 Component CCN: 14-3477		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 1/7/2021 8:31 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			611 SOUTH MARSHALL			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			MCLEANSBORO		IL 62859		2.00	
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00		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							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			HAMILTON				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1326

Period:

Worksheet S-8

Component CCN: 14-3477

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

Date/Time Prepared:

1/7/2021 8:31 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	17:00				11.00

Health Financial Systems		HAMILTON MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1326 Component CCN: 14-8529		Period: From 07/01/2019 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 1/7/2021 8:31 am	
		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1112 OAK STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CARMI	IL	62869	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
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
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	WHITE		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		08:00	17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1326

Period:

Worksheet S-8

Component CCN: 14-8529

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

Date/Time Prepared:

1/7/2021 8:31 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	08:00	15:00	09:00	15:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1326

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

Worksheet S-10

Date/Time Prepared:
1/7/2021 8:31 am

			1.00	
	Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.466329	1.00
	Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid		2,681,381	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		4,514,658	6.00
7.00	Medicaid cost (line 1 times line 6)		2,105,316	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)		0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone CHIP		11,200	9.00
10.00	Stand-alone CHIP charges		25,531	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		11,906	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		706	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)		706	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)	31,483	0	31,483
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	14,681	0	14,681
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	14,681	0	14,681
				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)		617,624	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		154,296	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		237,379	27.01
28.00	Non-Medicare bad debt expense (see instructions)		380,245	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		260,402	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		275,083	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		275,789	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1326

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

Worksheet A

Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		948,545	948,545	1,033,325	1,981,870	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		521,058	521,058	111,334	632,392	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	54,561	1,437,564	1,492,125	0	1,492,125	4.00
5.01	00540	NONPATIENT TELEPHONES	0	38,185	38,185	0	38,185	5.01
5.02	00550	DATA PROCESSING	109,868	696,288	806,156	0	806,156	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	56,182	2,767	58,949	0	58,949	5.03
5.04	00570	ADMITTING	0	0	0	160,008	160,008	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	452,946	67,659	520,605	-154,705	365,900	5.05
5.06	00590	OTHER ADMIN & GENERAL	316,039	577,257	893,296	-45,013	848,283	5.06
7.00	00700	OPERATION OF PLANT	108,100	576,116	684,216	8,256	692,472	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,609	52,609	0	52,609	8.00
9.00	00900	HOUSEKEEPING	130,135	25,856	155,991	0	155,991	9.00
10.00	01000	DIETARY	0	102,174	102,174	0	102,174	10.00
13.00	01300	NURSING ADMINISTRATION	296,683	11,916	308,599	0	308,599	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	-758	-758	758	0	14.00
15.00	01500	PHARMACY	177,123	334,050	511,173	-188,029	323,144	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	173,070	36,391	209,461	0	209,461	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	78,660	78,660	0	78,660	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,322,109	227,946	1,550,055	-5,515	1,544,540	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	152,638	222,433	375,071	-79,454	295,617	50.00
53.00	05300	ANESTHESIOLOGY	0	38,251	38,251	-23,213	15,038	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	305,892	324,025	629,917	-18,366	611,551	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	44,890	44,890	0	44,890	58.00
60.00	06000	LABORATORY	469,056	462,269	931,325	-14,089	917,236	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	92,790	48,133	140,923	-28,942	111,981	65.00
66.00	06600	PHYSICAL THERAPY	520,178	9,173	529,351	-153,186	376,165	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	153,113	153,113	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,789	17,789	0	17,789	68.00
69.00	06900	ELECTROCARDIOLOGY	0	35,557	35,557	0	35,557	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	27,152	27,152	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	13,965	13,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	251,062	251,062	73.00
76.00	03610	SLEEP LAB	0	18,000	18,000	0	18,000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	201,749	153,650	355,399	-6,564	348,835	76.01
76.97	07697	CARDIAC REHABILITATION	8,937	1,603	10,540	0	10,540	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	749,122	602,608	1,351,730	-5,303	1,346,427	88.00
88.01	08801	RURAL HEALTH CLINIC II	391,649	222,905	614,554	-112,843	501,711	88.01
91.00	09100	EMERGENCY	451,270	1,381,766	1,833,036	-26,848	1,806,188	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		896,903	896,903	-896,903	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,540,097	10,214,238	16,754,335	0	16,754,335	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	6,540,097	10,214,238	16,754,335	0	16,754,335	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1326

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

Worksheet A

Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-72,954	1,908,916	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	632,392	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-285,526	1,206,599	4.00
5.01	00540	NONPATIENT TELEPHONES	-3,971	34,214	5.01
5.02	00550	DATA PROCESSING	0	806,156	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	58,949	5.03
5.04	00570	ADMITTING	0	160,008	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	365,900	5.05
5.06	00590	OTHER ADMIN & GENERAL	-86,920	761,363	5.06
7.00	00700	OPERATION OF PLANT	0	692,472	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,609	8.00
9.00	00900	HOUSEKEEPING	0	155,991	9.00
10.00	01000	DIETARY	-500	101,674	10.00
13.00	01300	NURSING ADMINISTRATION	0	308,599	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-95,776	227,368	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,079	207,382	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-78,660	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-362,772	1,181,768	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-58,605	237,012	50.00
53.00	05300	ANESTHESIOLOGY	0	15,038	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,351	610,200	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	44,890	58.00
60.00	06000	LABORATORY	-62,724	854,512	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	111,981	65.00
66.00	06600	PHYSICAL THERAPY	-4,462	371,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	153,113	67.00
68.00	06800	SPEECH PATHOLOGY	0	17,789	68.00
69.00	06900	ELECTROCARDIOLOGY	-12,483	23,074	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,531	24,621	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	13,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-6,871	244,191	73.00
76.00	03610	SLEEP LAB	0	18,000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	348,835	76.01
76.97	07697	CARDIAC REHABILITATION	-1,350	9,190	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,346,427	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	501,711	88.01
91.00	09100	EMERGENCY	-651,112	1,155,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,790,647	14,963,688	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,790,647	14,963,688	200.00

RECLASSIFICATIONS

Provider CCN: 14-1326

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

Worksheet A-6

Date/Time Prepared:
1/7/2021 8:31 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	43,709		1.00
	0		0	43,709		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	896,903		1.00
	0		0	896,903		
	C - ADMITTING					
1.00	ADMITTING	5.04	150,982	9,026		1.00
	0		150,982	9,026		
	D - IMPLANTS					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	13,965		1.00
	0		0	13,965		
	E - RHC BILLER					
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	5,303	0		1.00
	TOTALS		5,303	0		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	45,207		1.00
2.00	CENTRAL SERVICE & SUPPLY	14.00	0	2,754		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
	0		0	47,961		
	G - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	251,062		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
	0		0	251,062		
	I - RENT & LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	104,206		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	99,841		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
	0		0	204,047		
	J - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	15,201		1.00
2.00		0.00	0	0		2.00
	0		0	15,201		
	K - OCCUPATIONAL THERAPIST					
1.00	OCCUPATIONAL THERAPY	67.00	153,113	0		1.00
	0		153,113	0		
	L - ELIMINATE NEGATIVE BALANCE					
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	18,055		1.00
	0		0	18,055		
500.00	Grand Total: Increases		309,398	1,499,929		500.00

RECLASSIFICATIONS

Provider CCN: 14-1326

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

Worksheet A-6

Date/Time Prepared:
1/7/2021 8:31 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	OTHER ADMIN & GENERAL	5.06	0	43,709	12		1.00
	0		0	43,709			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	896,903	11		1.00
	0		0	896,903			
	C - ADMITTING						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	150,982	9,026	0		1.00
	0		150,982	9,026			
	D - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	13,965	0		1.00
	0		0	13,965			
	E - RHC BILLER						
1.00	RURAL HEALTH CLINIC	88.00	5,303	0	0		1.00
	TOTALS		5,303	0			
	F - MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	23,137	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	5,325	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	10,671	0		3.00
4.00	EMERGENCY	91.00	0	8,428	0		4.00
5.00	PHARMACY	15.00	0	400	0		5.00
	0		0	47,961			
	G - DRUGS						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	19,988	0		1.00
2.00	PHARMACY	15.00	0	187,615	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	3,287	0		3.00
4.00	OPERATING ROOM	50.00	0	1,837	0		4.00
5.00	ANESTHESIOLOGY	53.00	0	2,276	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,931	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	14,693	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	15	0		8.00
9.00	EMERGENCY	91.00	0	18,420	0		9.00
	0		0	251,062			
	I - RENT & LEASE EXPENSE						
1.00	OTHER ADMIN & GENERAL	5.06	0	1,304	10		1.00
2.00	OPERATION OF PLANT	7.00	0	6,945	10		2.00
3.00	PHARMACY	15.00	0	14	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2,228	0		4.00
5.00	OPERATING ROOM	50.00	0	40,515	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	15,612	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,435	0		7.00
8.00	LABORATORY	60.00	0	14,089	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	3,578	0		9.00
10.00	RURAL HEALTH CLINIC II	88.01	0	104,206	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	58	0		11.00
12.00	CENTRAL SERVICE & SUPPLY	14.00	0	63	0		12.00
	0		0	204,047			
	J - UTILITY EXPENSE						
1.00	SENIOR ENRICHMENT CENTER	76.01	0	6,564	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	8,637	0		2.00
	0		0	15,201			
	K - OCCUPATIONAL THERAPIST						
1.00	PHYSICAL THERAPY	66.00	153,113	0	0		1.00
	0		153,113	0			
	L - ELIMINATE NEGATIVE BALANCE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	18,055	0		1.00
	0		0	18,055			
500.00	Grand Total: Decreases		309,398	1,499,929			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
1/7/2021 8:31 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	69,760	0	0	0	0	1.00	
2.00	Land Improvements	499,729	0	0	0	0	2.00	
3.00	Buildings and Fixtures	21,717,317	0	0	0	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	6,448,841	774,799	0	774,799	0	6.00	
7.00	HIT designated Assets	727,424	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	29,463,071	774,799	0	774,799	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	29,463,071	774,799	0	774,799	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	69,760	0				1.00	
2.00	Land Improvements	499,729	0				2.00	
3.00	Buildings and Fixtures	21,717,317	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	7,223,640	0				6.00	
7.00	HIT designated Assets	727,424	0				7.00	
8.00	Subtotal (sum of lines 1-7)	30,237,870	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	30,237,870	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	948,545	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	521,058	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,469,603	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	948,545				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	521,058				2.00
3.00	Total (sum of lines 1-2)	0	1,469,603				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	22,286,806	0	22,286,806	0.737049	32,216	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,951,064	0	7,951,064	0.262951	11,493	2.00
3.00	Total (sum of lines 1-2)	30,237,870	0	30,237,870	1.000000	43,709	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	32,216	948,545	104,206	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	11,493	521,058	99,841	2.00
3.00	Total (sum of lines 1-2)	0	0	43,709	1,469,603	204,047	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	823,949	32,216	0	0	1,908,916	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,493	0	0	632,392	2.00
3.00	Total (sum of lines 1-2)	823,949	43,709	0	0	2,541,308	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1326

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

Worksheet A-8

Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-91,233	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,616	OTHER ADMIN & GENERAL	5.06	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,084,673			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-500	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-2,531	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-6,871	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,079	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,014	OTHER ADMIN & GENERAL	5.06	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-78,660	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	WOMEN'S WELLNESS	B	-54,397	LABORATORY	60.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1326

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

Worksheet A-8

Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	THERAPY PROVIDED TO VNA	B	-4,462	PHYSICAL THERAPY	66.00	0	33.01
33.02	NURSING CENTER TELEPHONE SERVICES	B	-137	NONPATIENT TELEPHONES	5.01	0	33.02
33.03	NURSING CENTER LAB SERVICES	B	-8,327	LABORATORY	60.00	0	33.03
33.04	SELF INSURED DOMESTIC CLAIMS EXPENSE	A	-245,671	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	RETAIL PHARMACY 340B	A	-95,776	PHARMACY	15.00	0	33.05
34.00	NON-ALLOWABLE FUNDRAISING	A	-69,461	OTHER ADMIN & GENERAL	5.06	0	34.00
34.01	NON-ALLOWABLE ADVERTISING	A	-2,658	OTHER ADMIN & GENERAL	5.06	0	34.01
34.03	NON-ALLOWABLE FUNDRAISING BENEFITS	A	-7,157	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.03
35.00	NON-ALLOWABLE LOBBYING DUES	A	-7,171	OTHER ADMIN & GENERAL	5.06	0	35.00
35.01	NON-ALLOWABLE PATIENT TELEPHONE EXPE	A	-3,834	NONPATIENT TELEPHONES	5.01	0	35.01
36.00	BOND ISSUANCE COSTS	A	18,279	CAP REL COSTS-BLDG & FIXT	1.00	11	36.00
39.00	AMBULANCE COSTS IN ER	A	-3,000	EMERGENCY	91.00	0	39.00
40.00	PHYSICIAN BENEFITS	A	-32,698	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,790,647				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: 14-1326

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

Worksheet A-8-2

Date/Time Prepared:
1/7/2021 8:31 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	362,772	362,772	0	0	0	1.00
2.00	50.00	OPERATING ROOM	58,605	58,605	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	1,351	1,351	0	0	0	3.00
4.00	60.00	LABORATORY	16,923	0	16,923	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	12,483	12,483	0	0	0	5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	30,640	0	30,640	0	0	6.00
7.00	76.97	CARDIAC REHABILITATION	1,350	1,350	0	0	0	7.00
8.00	91.00	EMERGENCY	48,000	0	48,000	0	0	8.00
9.00	91.00	EMERGENCY	1,231,450	648,112	583,338	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,763,574	1,084,673	678,901		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	0	0	0	0	0	6.00
7.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	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	362,772		1.00
2.00	50.00	OPERATING ROOM	0	0	0	58,605		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,351		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	12,483		5.00
6.00	76.01	SENIOR ENRICHMENT CENTER	0	0	0	0		6.00
7.00	76.97	CARDIAC REHABILITATION	0	0	0	1,350		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	91.00	EMERGENCY	0	0	0	648,112		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,084,673		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/7/2021 8:31 am		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						158	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						0.00	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	298.50	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	77.89	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.95	38.95	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						23,250	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						23,250	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						23,250	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						77.89	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						60,754	22.00
23.00	Total salary equivalency (see instructions)						60,754	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						6,154	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						6,154	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						6,154	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						6,154	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1326		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/7/2021 8:31 am		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.89	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						60,754	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						6,154	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						66,908	63.00
64.00	Total cost of outside supplier services (from your records)						17,789	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						6,154	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						6,154	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,908,916	1,908,916			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	632,392		632,392		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,206,599	7,022	216	1,213,837	4.00
5.01	00540	NONPATIENT TELEPHONES	34,214	936	0	0	35,150 5.01
5.02	00550	DATA PROCESSING	806,156	24,622	199,092	21,488	555 5.02
5.03	00560	PURCHASING RECEIVING AND STORES	58,949	53,129	497	10,988	555 5.03
5.04	00570	ADMITTING	160,008	3,277	0	29,529	925 5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	365,900	33,937	0	60,095	1,850 5.05
5.06	00590	OTHER ADMIN & GENERAL	761,363	210,154	7,711	53,707	2,775 5.06
7.00	00700	OPERATION OF PLANT	692,472	166,644	19,391	21,142	370 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,609	22,375	1,351	0	0 8.00
9.00	00900	HOUSEKEEPING	155,991	0	0	25,452	0 9.00
10.00	01000	DIETARY	101,674	0	545	0	0 10.00
13.00	01300	NURSING ADMINISTRATION	308,599	39,601	1,300	58,025	1,665 13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	64	0	0 14.00
15.00	01500	PHARMACY	227,368	27,454	2,543	34,641	370 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207,382	29,186	3,469	33,849	1,110 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,181,768	312,577	43,148	212,084	8,325 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	237,012	156,814	84,866	29,853	1,295 50.00
53.00	05300	ANESTHESIOLOGY	15,038	0	19,324	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	610,200	103,076	167,220	59,826	2,775 54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	44,890	0	0	0	0 58.00
60.00	06000	LABORATORY	854,512	40,374	41,714	91,737	1,850 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	111,981	16,384	17,508	18,148	1,110 65.00
66.00	06600	PHYSICAL THERAPY	371,703	75,949	4,160	71,790	740 66.00
67.00	06700	OCCUPATIONAL THERAPY	153,113	28,858	1,580	29,946	740 67.00
68.00	06800	SPEECH PATHOLOGY	17,789	2,317	127	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	23,074	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,621	0	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,965	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	244,191	0	0	0	0 73.00
76.00	03610	SLEEP LAB	18,000	8,777	0	0	0 76.00
76.01	03950	SENIOR ENRICHMENT CENTER	348,835	78,594	0	39,458	1,295 76.01
76.97	07697	CARDIAC REHABILITATION	9,190	8,145	0	1,748	185 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,346,427	161,518	9,164	145,475	1,665 88.00
88.01	08801	RURAL HEALTH CLINIC II	501,711	45,078	4,471	76,598	1,850 88.01
91.00	09100	EMERGENCY	1,155,076	107,616	2,931	88,258	2,405 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,963,688	1,764,414	632,392	1,213,837	34,410 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,268	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135,234	0	0	740 192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	14,963,688	1,908,916	632,392	1,213,837	35,150 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1326

Period:
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	1,051,913					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	13,661	137,779				5.03
5.04	00570	ADMITTING	34,153	296	228,188			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	68,306	600	0	530,688		5.05
5.06	00590	OTHER ADMIN & GENERAL	47,814	9,130	0	0	1,092,654	5.06
7.00	00700	OPERATION OF PLANT	13,661	7,292	0	0	920,972	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102	0	0	76,437	8.00
9.00	00900	HOUSEKEEPING	0	3,724	0	0	185,167	9.00
10.00	01000	DIETARY	0	2,735	0	0	104,954	10.00
13.00	01300	NURSING ADMINISTRATION	54,645	218	0	0	464,053	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	64	14.00
15.00	01500	PHARMACY	20,492	2,340	0	0	315,208	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,814	1,548	0	0	324,358	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	109,290	14,024	102,416	70,253	2,053,885	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,645	11,176	402	17,434	593,497	50.00
53.00	05300	ANESTHESIOLOGY	6,831	1,916	57	1,336	44,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,984	7,837	10,388	107,066	1,109,372	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	75	5,749	50,714	58.00
60.00	06000	LABORATORY	54,645	51,082	23,269	122,625	1,281,808	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,153	1,428	3,292	4,130	208,134	65.00
66.00	06600	PHYSICAL THERAPY	47,814	755	16,798	23,055	612,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,661	287	8,263	8,757	245,205	67.00
68.00	06800	SPEECH PATHOLOGY	0	23	466	706	21,428	68.00
69.00	06900	ELECTROCARDIOLOGY	0	153	449	5,942	29,618	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,125	7,799	11,504	48,049	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	2,122	0	3,093	19,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	54,512	48,371	347,074	73.00
76.00	03610	SLEEP LAB	0	0	0	2,735	29,512	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	54,645	1,834	0	18,286	542,947	76.01
76.97	07697	CARDIAC REHABILITATION	0	38	0	458	19,764	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	143,443	1,679	0	19,840	1,829,211	88.00
88.01	08801	RURAL HEALTH CLINIC II	95,628	1,002	0	8,721	735,059	88.01
91.00	09100	EMERGENCY	95,628	10,313	2	50,627	1,512,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,051,913	137,779	228,188	530,688	14,818,446	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	9,268	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	135,974	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,051,913	137,779	228,188	530,688	14,963,688	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1326

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Cost Center Description			OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	1,092,654					5.06
7.00	00700	OPERATION OF PLANT	72,547	993,519				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,021	15,775	98,233			8.00
9.00	00900	HOUSEKEEPING	14,586	0	0	199,753		9.00
10.00	01000	DIETARY	8,267	0	0	0	113,221	10.00
13.00	01300	NURSING ADMINISTRATION	36,554	27,920	0	562	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	5	0	0	0	0	14.00
15.00	01500	PHARMACY	24,830	19,356	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,550	20,577	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	161,792	220,373	73,429	62,307	113,221	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,751	110,558	3,421	17,819	0	50.00
53.00	05300	ANESTHESIOLOGY	3,506	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,387	72,671	1,624	10,092	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,995	0	162	0	0	58.00
60.00	06000	LABORATORY	100,971	28,465	0	7,642	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	16,395	11,551	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	48,269	53,546	9,267	9,139	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,315	20,346	3,520	4,476	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,688	1,634	283	323	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,333	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,785	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,511	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,340	0	0	0	0	73.00
76.00	03610	SLEEP LAB	2,325	6,188	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	42,769	55,411	0	7,676	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,557	5,742	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	144,091	113,875	761	33,153	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	57,902	31,781	0	0	0	88.01
91.00	09100	EMERGENCY	119,171	75,872	5,766	46,564	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,081,213	891,641	98,233	199,753	113,221	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	730	6,534	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,711	95,344	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,092,654	993,519	98,233	199,753	113,221	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Part I
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION	529,089					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	69				14.00
15.00	01500	PHARMACY	0	0	359,394			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	370,485		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	356,926	0	0	161,655	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,774	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	130,605	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	23	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	359,394	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	8,519	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	128,870	0	0	78,225	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	529,089	69	359,394	370,485	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	529,089	69	359,394	370,485	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,203,588	-197,125	3,006,463	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	806,820	0	806,820	50.00
53.00	05300	ANESTHESIOLOGY	0	48,008	0	48,008	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,281,146	0	1,281,146	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	54,871	0	54,871	58.00
60.00	06000	LABORATORY	0	1,549,491	0	1,549,491	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	197,125	197,125	64.00
65.00	06500	RESPIRATORY THERAPY	0	236,080	0	236,080	65.00
66.00	06600	PHYSICAL THERAPY	0	732,985	0	732,985	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	292,862	0	292,862	67.00
68.00	06800	SPEECH PATHOLOGY	0	25,356	0	25,356	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,951	0	31,951	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	51,880	0	51,880	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	20,714	0	20,714	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	733,808	0	733,808	73.00
76.00	03610	SLEEP LAB	0	38,025	0	38,025	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	657,322	0	657,322	76.01
76.97	07697	CARDIAC REHABILITATION	0	27,063	0	27,063	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,121,091	0	2,121,091	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	824,742	0	824,742	88.01
91.00	09100	EMERGENCY	0	1,967,324	0	1,967,324	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,705,127	0	14,705,127	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	16,532	0	16,532	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	242,029	0	242,029	192.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	14,963,688	0	14,963,688	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,022	216	7,238	4.00
5.01	00540	NONPATIENT TELEPHONES	0	936	0	936	5.01
5.02	00550	DATA PROCESSING	0	24,622	199,092	223,714	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	53,129	497	53,626	5.03
5.04	00570	ADMITTING	0	3,277	0	3,277	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	33,937	0	33,937	5.05
5.06	00590	OTHER ADMIN & GENERAL	0	210,154	7,711	217,865	5.06
7.00	00700	OPERATION OF PLANT	0	166,644	19,391	186,035	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	22,375	1,351	23,726	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	545	545	10.00
13.00	01300	NURSING ADMINISTRATION	0	39,601	1,300	40,901	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	64	64	14.00
15.00	01500	PHARMACY	0	27,454	2,543	29,997	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,186	3,469	32,655	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	312,577	43,148	355,725	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	156,814	84,866	241,680	50.00
53.00	05300	ANESTHESIOLOGY	0	0	19,324	19,324	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	103,076	167,220	270,296	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	40,374	41,714	82,088	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	16,384	17,508	33,892	65.00
66.00	06600	PHYSICAL THERAPY	0	75,949	4,160	80,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28,858	1,580	30,438	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,317	127	2,444	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	8,777	0	8,777	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	78,594	0	78,594	76.01
76.97	07697	CARDIAC REHABILITATION	0	8,145	0	8,145	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	161,518	9,164	170,682	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	45,078	4,471	49,549	88.01
91.00	09100	EMERGENCY	0	107,616	2,931	110,547	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,764,414	632,392	2,396,806	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,268	0	9,268	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135,234	0	135,234	192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,908,916	632,392	2,541,308	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	936					5.01
5.02	00550	DATA PROCESSING	15	223,857				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	15	2,907	56,614			5.03
5.04	00570	ADMITTING	25	7,268	121	10,867		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	49	14,536	247	0	49,127	5.05
5.06	00590	OTHER ADMIN & GENERAL	74	10,175	3,751	0	0	5.06
7.00	00700	OPERATION OF PLANT	10	2,907	2,996	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	42	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	1,530	0	0	9.00
10.00	01000	DIETARY	0	0	1,124	0	0	10.00
13.00	01300	NURSING ADMINISTRATION	44	11,629	90	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	10	4,361	962	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30	10,175	636	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	221	23,258	5,763	4,878	6,504	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34	11,629	4,592	19	1,614	50.00
53.00	05300	ANESTHESIOLOGY	0	1,454	787	3	124	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74	8,722	3,220	495	9,912	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	4	532	58.00
60.00	06000	LABORATORY	49	11,629	20,990	1,108	11,351	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	30	7,268	587	157	382	65.00
66.00	06600	PHYSICAL THERAPY	20	10,175	310	800	2,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	20	2,907	118	393	811	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	9	22	65	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	63	21	550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,695	371	1,065	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	872	0	286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,596	4,478	73.00
76.00	03610	SLEEP LAB	0	0	0	0	253	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	34	11,629	753	0	1,693	76.01
76.97	07697	CARDIAC REHABILITATION	5	0	16	0	42	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	44	30,526	690	0	1,837	88.00
88.01	08801	RURAL HEALTH CLINIC II	49	20,351	412	0	807	88.01
91.00	09100	EMERGENCY	64	20,351	4,238	0	4,687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	916	223,857	56,614	10,867	49,127	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	20	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	936	223,857	56,614	10,867	49,127	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			OTHER ADMIN & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL	232,185					5.06
7.00	00700	OPERATION OF PLANT	15,416	207,490				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,279	3,295	28,342			8.00
9.00	00900	HOUSEKEEPING	3,100	0	0	4,782		9.00
10.00	01000	DIETARY	1,757	0	0	0	3,426	10.00
13.00	01300	NURSING ADMINISTRATION	7,768	5,831	0	13	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1	0	0	0	0	14.00
15.00	01500	PHARMACY	5,276	4,042	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,429	4,297	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,378	46,025	21,183	1,490	3,426	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,935	23,089	987	427	0	50.00
53.00	05300	ANESTHESIOLOGY	745	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,570	15,177	469	242	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	849	0	47	0	0	58.00
60.00	06000	LABORATORY	21,456	5,945	0	183	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,484	2,412	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,257	11,183	2,674	219	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,104	4,249	1,016	107	0	67.00
68.00	06800	SPEECH PATHOLOGY	359	341	82	8	0	68.00
69.00	06900	ELECTROCARDIOLOGY	496	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	804	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	321	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,810	0	0	0	0	73.00
76.00	03610	SLEEP LAB	494	1,292	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	9,088	11,572	0	184	0	76.01
76.97	07697	CARDIAC REHABILITATION	331	1,199	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	30,619	23,782	220	794	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,304	6,637	0	0	0	88.01
91.00	09100	EMERGENCY	25,324	15,845	1,664	1,115	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	229,754	186,213	28,342	4,782	3,426	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	155	1,365	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,276	19,912	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	232,185	207,490	28,342	4,782	3,426	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICE & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION	66,622					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	65				14.00
15.00	01500	PHARMACY	0	0	44,855			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	53,424		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,943	0	0	23,311	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,379	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	18,833	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	22	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	44,855	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	1,073	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	16,227	0	0	11,280	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,622	65	44,855	53,424	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,622	65	44,855	53,424	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	OTHER ADMIN & GENERAL					5.06
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		572,370	0	572,370	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		298,563	0	298,563	50.00
53.00	05300	ANESTHESIOLOGY		22,437	0	22,437	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		327,534	0	327,534	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		1,432	0	1,432	58.00
60.00	06000	LABORATORY		174,179	0	174,179	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		48,320	0	48,320	65.00
66.00	06600	PHYSICAL THERAPY		118,309	0	118,309	66.00
67.00	06700	OCCUPATIONAL THERAPY		44,342	0	44,342	67.00
68.00	06800	SPEECH PATHOLOGY		3,330	0	3,330	68.00
69.00	06900	ELECTROCARDIOLOGY		1,130	0	1,130	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		3,978	0	3,978	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		1,501	0	1,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		57,739	0	57,739	73.00
76.00	03610	SLEEP LAB		10,816	0	10,816	76.00
76.01	03950	SENIOR ENRICHMENT CENTER		114,855	0	114,855	76.01
76.97	07697	CARDIAC REHABILITATION		9,748	0	9,748	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		260,061	0	260,061	88.00
88.01	08801	RURAL HEALTH CLINIC II		90,566	0	90,566	88.01
91.00	09100	EMERGENCY		211,868	0	211,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,373,078	0	2,373,078	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		10,788	0	10,788	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		157,442	0	157,442	192.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,541,308	0	2,541,308	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1326

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

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Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	81,560				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		620,899			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	300	212	6,206,403		4.00
5.01	00540	NONPATIENT TELEPHONES	40	0	0	190	5.01
5.02	00550	DATA PROCESSING	1,052	195,473	109,868	3	154
5.03	00560	PURCHASING RECEIVING AND STORES	2,270	488	56,182	3	2
5.04	00570	ADMITTING	140	0	150,982	5	5
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,450	0	307,267	10	10
5.06	00590	OTHER ADMIN & GENERAL	8,979	7,571	274,604	15	7
7.00	00700	OPERATION OF PLANT	7,120	19,039	108,100	2	2
8.00	00800	LAUNDRY & LINEN SERVICE	956	1,326	0	0	0
9.00	00900	HOUSEKEEPING	0	0	130,135	0	0
10.00	01000	DIETARY	0	535	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,692	1,276	296,683	9	8
14.00	01400	CENTRAL SERVICE & SUPPLY	0	63	0	0	0
15.00	01500	PHARMACY	1,173	2,497	177,123	2	3
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	3,406	173,070	6	7
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,355	42,364	1,084,411	45	16
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,700	83,324	152,638	7	8
53.00	05300	ANESTHESIOLOGY	0	18,973	0	0	1
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,404	164,181	305,892	15	6
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	1,725	40,956	469,056	10	8
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	700	17,190	92,790	6	5
66.00	06600	PHYSICAL THERAPY	3,245	4,084	367,065	4	7
67.00	06700	OCCUPATIONAL THERAPY	1,233	1,551	153,113	4	2
68.00	06800	SPEECH PATHOLOGY	99	125	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03610	SLEEP LAB	375	0	0	0	0
76.01	03950	SENIOR ENRICHMENT CENTER	3,358	0	201,749	7	8
76.97	07697	CARDIAC REHABILITATION	348	0	8,937	1	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,901	8,997	743,819	9	21
88.01	08801	RURAL HEALTH CLINIC II	1,926	4,390	391,649	10	14
91.00	09100	EMERGENCY	4,598	2,878	451,270	13	14
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,386	620,899	6,206,403	186	154
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	396	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,778	0	0	4	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,908,916	632,392	1,213,837	35,150	1,051,913
203.00		Unit cost multiplier (Wkst. B, Part I)	23.405051	1.018510	0.195578	185.000000	6,830.603896
204.00		Cost to be allocated (per Wkst. B, Part II)			7,238	936	223,857
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001166	4.926316	1,453.616883
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1326

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (INPATIENT CHARGES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	906,818					5.03
5.04	00570	ADMITTING	1,946	8,078,912				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,952	0	31,533,770			5.05
5.06	00590	OTHER ADMIN & GENERAL	60,090	0	0	-1,092,654	13,871,034	5.06
7.00	00700	OPERATION OF PLANT	47,991	0	0	0	920,972	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	673	0	0	0	76,437	8.00
9.00	00900	HOUSEKEEPING	24,513	0	0	0	185,167	9.00
10.00	01000	DIETARY	18,002	0	0	0	104,954	10.00
13.00	01300	NURSING ADMINISTRATION	1,437	0	0	0	464,053	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	64	14.00
15.00	01500	PHARMACY	15,403	0	0	0	315,208	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,190	0	0	0	324,358	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	92,302	3,626,007	4,174,512	0	2,053,885	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	73,556	14,230	1,035,950	0	593,497	50.00
53.00	05300	ANESTHESIOLOGY	12,611	2,002	79,406	0	44,502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,580	367,772	6,362,005	0	1,109,372	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,639	341,603	0	50,714	58.00
60.00	06000	LABORATORY	336,205	823,840	7,286,159	0	1,281,808	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	9,399	116,561	245,387	0	208,134	65.00
66.00	06600	PHYSICAL THERAPY	4,968	594,711	1,369,977	0	612,764	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,887	292,563	520,354	0	245,205	67.00
68.00	06800	SPEECH PATHOLOGY	152	16,490	41,945	0	21,428	68.00
69.00	06900	ELECTROCARDIOLOGY	1,004	15,914	353,091	0	29,618	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,152	276,132	683,589	0	48,049	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,965	0	183,787	0	19,180	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,929,967	2,874,288	0	347,074	73.00
76.00	03610	SLEEP LAB	0	0	162,517	0	29,512	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	12,069	0	1,086,602	0	542,947	76.01
76.97	07697	CARDIAC REHABILITATION	253	0	27,189	0	19,764	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,049	0	1,178,906	0	1,829,211	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,593	0	518,209	0	735,059	88.01
91.00	09100	EMERGENCY	67,876	84	3,008,294	0	1,512,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	906,818	8,078,912	31,533,770	-1,092,654	13,725,792	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	9,268	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	135,974	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	137,779	228,188	530,688		1,092,654	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.151937	0.028245	0.016829		0.078772	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	56,614	10,867	49,127		232,185	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.062431	0.001345	0.001558		0.016739	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: 14-1326

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

Worksheet B-1

Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	
			7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
7.00	00700	OPERATION OF PLANT	60,209					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	956	83,883				8.00
9.00	00900	HOUSEKEEPING	0	0	11,737			9.00
10.00	01000	DIETARY	0	0	0	10,583		10.00
13.00	01300	NURSING ADMINISTRATION	1,692	0	33	0	75,892	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,173	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,247	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,355	62,702	3,661	10,583	51,197	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,700	2,921	1,047	0	4,988	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,404	1,387	593	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	138	0	0	0	58.00
60.00	06000	LABORATORY	1,725	0	449	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	700	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,245	7,913	537	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,233	3,006	263	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	99	242	19	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03610	SLEEP LAB	375	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	3,358	0	451	0	1,222	76.01
76.97	07697	CARDIAC REHABILITATION	348	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,901	650	1,948	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,926	0	0	0	0	88.01
91.00	09100	EMERGENCY	4,598	4,924	2,736	0	18,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,035	83,883	11,737	10,583	75,892	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	396	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,778	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	993,519	98,233	199,753	113,221	529,089	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.501171	1.171072	17.019085	10.698384	6.971604	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	207,490	28,342	4,782	3,426	66,622	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.446163	0.337875	0.407429	0.323727	0.877853	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: 14-1326

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

Worksheet B-1

Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description			CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMIN & GENERAL						5.06
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
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	41,117					14.00
15.00	01500	PHARMACY	0	251,062				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	40,210			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	17,545	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	14,175	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,152	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,965	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	251,062	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	8,490	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,117	251,062	40,210	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	69	359,394	370,485	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001678	1.431495	9.213753	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	65	44,855	53,424	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001581	0.178661	1.328625	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 14-1326

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

Worksheet B-2

Date/Time Prepared:
1/7/2021 8:31 am

		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
7.00		IV THERAPY		1	30.00	-197,125 7.00
8.00		IV THERAPY		1	64.00	197,125 8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/7/2021 8:31 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,006,463		3,006,463	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	806,820		806,820	0	0	50.00
53.00	05300	ANESTHESIOLOGY	48,008		48,008	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,281,146		1,281,146	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	54,871		54,871	0	0	58.00
60.00	06000	LABORATORY	1,549,491		1,549,491	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	197,125		197,125	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	236,080	0	236,080	0	0	65.00
66.00	06600	PHYSICAL THERAPY	732,985	0	732,985	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	292,862	0	292,862	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,356	0	25,356	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,951		31,951	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,880		51,880	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	20,714		20,714	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	733,808		733,808	0	0	73.00
76.00	03610	SLEEP LAB	38,025		38,025	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	657,322		657,322	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	27,063		27,063	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,121,091		2,121,091	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	824,742		824,742	0	0	88.01
91.00	09100	EMERGENCY	1,967,324		1,967,324	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	156,043		156,043		0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,861,170	0	14,861,170	0	0	200.00
201.00		Less Observation Beds	156,043		156,043			201.00
202.00		Total (see instructions)	14,705,127	0	14,705,127	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/7/2021 8:31 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,376,040		3,376,040		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14,230	1,021,720	1,035,950	0.778821	0.000000
53.00	05300	ANESTHESIOLOGY	2,002	77,404	79,406	0.604589	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	367,772	5,994,233	6,362,005	0.201375	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,639	338,964	341,603	0.160628	0.000000
60.00	06000	LABORATORY	823,840	6,462,319	7,286,159	0.212662	0.000000
64.00	06400	INTRAVENOUS THERAPY	249,967	332,396	582,363	0.338492	0.000000
65.00	06500	RESPIRATORY THERAPY	116,561	128,826	245,387	0.962072	0.000000
66.00	06600	PHYSICAL THERAPY	594,711	775,266	1,369,977	0.535035	0.000000
67.00	06700	OCCUPATIONAL THERAPY	292,563	227,791	520,354	0.562813	0.000000
68.00	06800	SPEECH PATHOLOGY	16,490	25,455	41,945	0.604506	0.000000
69.00	06900	ELECTROCARDIOLOGY	15,914	337,177	353,091	0.090489	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	276,132	407,457	683,589	0.075894	0.000000
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	183,787	183,787	0.112707	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,929,967	944,321	2,874,288	0.255301	0.000000
76.00	03610	SLEEP LAB	0	162,517	162,517	0.233976	0.000000
76.01	03950	SENIOR ENRICHMENT CENTER	0	1,086,602	1,086,602	0.604934	0.000000
76.97	07697	CARDIAC REHABILITATION	0	27,189	27,189	0.995366	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,178,906	1,178,906		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	518,209	518,209		88.01
91.00	09100	EMERGENCY	84	3,008,210	3,008,294	0.653967	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	216,109	216,109	0.722057	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	8,078,912	23,454,858	31,533,770		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,078,912	23,454,858	31,533,770		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03610 SLEEP LAB	0.000000			76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
1/7/2021 8:31 am

				Title XVIII		Hospital	Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	298,563	1,035,950	0.288202	7,399	2,132	50.00
53.00	05300	ANESTHESIOLOGY	22,437	79,406	0.282561	1,238	350	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	327,534	6,362,005	0.051483	199,407	10,266	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,432	341,603	0.004192	2,639	11	58.00
60.00	06000	LABORATORY	174,179	7,286,159	0.023905	389,338	9,307	60.00
64.00	06400	INTRAVENOUS THERAPY	0	582,363	0.000000	4,038	0	64.00
65.00	06500	RESPIRATORY THERAPY	48,320	245,387	0.196913	42,141	8,298	65.00
66.00	06600	PHYSICAL THERAPY	118,309	1,369,977	0.086358	22,311	1,927	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,342	520,354	0.085215	11,527	982	67.00
68.00	06800	SPEECH PATHOLOGY	3,330	41,945	0.079390	2,219	176	68.00
69.00	06900	ELECTROCARDIOLOGY	1,130	353,091	0.003200	7,222	23	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,978	683,589	0.005819	79,593	463	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,501	183,787	0.008167	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,739	2,874,288	0.020088	471,188	9,465	73.00
76.00	03610	SLEEP LAB	10,816	162,517	0.066553	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	114,855	1,086,602	0.105701	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	9,748	27,189	0.358527	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	260,061	1,178,906	0.220595	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	90,566	518,209	0.174767	0	0	88.01
91.00	09100	EMERGENCY	211,868	3,008,294	0.070428	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	29,707	216,109	0.137463	0	0	92.00
200.00		Total (lines 50 through 199)	1,830,415	28,157,730		1,240,260	43,400	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description			Title XVIII			Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,035,950	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	79,406	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,362,005	0.000000	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	341,603	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	7,286,159	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	582,363	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	245,387	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,369,977	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	520,354	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	41,945	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	353,091	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	683,589	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	183,787	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,874,288	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	162,517	0.000000	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0	0	0	1,086,602	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	27,189	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,178,906	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	518,209	0.000000	88.01
91.00	09100	EMERGENCY	0	0	0	3,008,294	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	216,109	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	28,157,730		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1326

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

Worksheet D
Part IV
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	7,399	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,238	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	199,407	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	2,639	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	389,338	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	4,038	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	42,141	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	22,311	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	11,527	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,219	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,222	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	79,593	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	471,188	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03950	SENIOR ENRICHMENT CENTER	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,240,260	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/7/2021 8:31 am

			Title XVIII		Hospital		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.778821	0	451,150	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.604589	0	33,813	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.201375	0	2,731,159	0	0	54.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.160628	0	156,939	0	0	58.00	
60.00	06000	LABORATORY	0.212662	0	3,077,257	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.338492	0	239,069	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.962072	0	79,163	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.535035	0	345,474	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.562813	0	122,539	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.604506	0	10,575	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.090489	0	169,731	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.075894	0	153,761	0	0	71.00	
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.112707	0	120,774	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.255301	0	477,945	0	0	73.00	
76.00	03610	SLEEP LAB	0.233976	0	42,845	0	0	76.00	
76.01	03950	SENIOR ENRICHMENT CENTER	0.604934	0	1,086,602	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	0.995366	0	18,114	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC						88.00	
88.01	08801	RURAL HEALTH CLINIC II						88.01	
91.00	09100	EMERGENCY	0.653967	0	1,120,216	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.722057	0	131,968	0	0	92.00	
200.00		Subtotal (see instructions)		0	10,569,094	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	10,569,094	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/7/2021 8:31 am

			Title XVIII		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	351,365	0		50.00
53.00	05300	ANESTHESIOLOGY	20,443	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	549,987	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	25,209	0		58.00
60.00	06000	LABORATORY	654,416	0		60.00
64.00	06400	INTRAVENOUS THERAPY	80,923	0		64.00
65.00	06500	RESPIRATORY THERAPY	76,161	0		65.00
66.00	06600	PHYSICAL THERAPY	184,841	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	68,967	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,393	0		68.00
69.00	06900	ELECTROCARDIOLOGY	15,359	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,670	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	13,612	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	122,020	0		73.00
76.00	03610	SLEEP LAB	10,025	0		76.00
76.01	03950	SENIOR ENRICHMENT CENTER	657,322	0		76.01
76.97	07697	CARDIAC REHABILITATION	18,030	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
91.00	09100	EMERGENCY	732,584	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	95,288	0		92.00
200.00		Subtotal (see instructions)	3,694,615	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,694,615	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/7/2021 8:31 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,502	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,047	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)			871	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,144	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)			1,176	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			117	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)			18	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			659	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)			1,070	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)			1,006	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,006,463	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)			18,391	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)			2,829	25.00
26.00	Total swing-bed cost (see instructions)			2,078,178	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			928,285	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)			928,285	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)			886.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			584,283	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)			584,283	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1326

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

Worksheet D-1

Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					318,553	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					902,836	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)					948,683	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					891,940	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,840,623	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)					176	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					886.61	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					156,043	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1326

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

Worksheet D-1

Date/Time Prepared:
1/7/2021 8:31 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	572,370	3,006,463	0.190380	156,043	29,707	90.00
91.00	Nursing School cost	0	3,006,463	0.000000	156,043	0	91.00
92.00	Allied health cost	0	3,006,463	0.000000	156,043	0	92.00
93.00	All other Medical Education	0	3,006,463	0.000000	156,043	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/7/2021 8:31 am	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		727,733		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.778821	7,399	5,762	50.00
53.00	05300 ANESTHESIOLOGY	0.604589	1,238	748	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.201375	199,407	40,156	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.160628	2,639	424	58.00
60.00	06000 LABORATORY	0.212662	389,338	82,797	60.00
64.00	06400 INTRAVENOUS THERAPY	0.338492	4,038	1,367	64.00
65.00	06500 RESPIRATORY THERAPY	0.962072	42,141	40,543	65.00
66.00	06600 PHYSICAL THERAPY	0.535035	22,311	11,937	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.562813	11,527	6,488	67.00
68.00	06800 SPEECH PATHOLOGY	0.604506	2,219	1,341	68.00
69.00	06900 ELECTROCARDIOLOGY	0.090489	7,222	654	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.075894	79,593	6,041	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.112707	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.255301	471,188	120,295	73.00
76.00	03610 SLEEP LAB	0.233976	0	0	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.604934	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.995366	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100 EMERGENCY	0.653967	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.722057	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,240,260	318,553	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)		1,240,260		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1326 Component CCN: 14-Z326	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/7/2021 8:31 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.778821	1,979	1,541	50.00
53.00	05300 ANESTHESIOLOGY	0.604589	287	174	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.201375	83,984	16,912	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.160628	0	0	58.00
60.00	06000 LABORATORY	0.212662	266,466	56,667	60.00
64.00	06400 INTRAVENOUS THERAPY	0.338492	88,945	30,107	64.00
65.00	06500 RESPIRATORY THERAPY	0.962072	48,114	46,289	65.00
66.00	06600 PHYSICAL THERAPY	0.535035	375,455	200,882	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.562813	281,036	158,171	67.00
68.00	06800 SPEECH PATHOLOGY	0.604506	13,539	8,184	68.00
69.00	06900 ELECTROCARDIOLOGY	0.090489	7,048	638	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.075894	133,284	10,115	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.112707	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.255301	1,103,438	281,709	73.00
76.00	03610 SLEEP LAB	0.233976	0	0	76.00
76.01	03950 SENIOR ENRICHMENT CENTER	0.604934	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.995366	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100 EMERGENCY	0.653967	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.722057		0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,403,575	811,389	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,403,575		202.00

Health Financial Systems		HAMILTON MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/7/2021 8:31 am	
		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			3,694,615	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)			3,694,615	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			3,731,561	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)			27,693	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,494,621	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,209,247	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			2,209,247	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			2,209,247	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)			164,182	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			106,718	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			111,009	36.00
37.00	Subtotal (see instructions)			2,315,965	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			2,315,965	40.00
40.01	Sequestration adjustment (see instructions)			38,677	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			1,983,956	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)			293,332	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: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
1/7/2021 8:31 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		688,398		1,946,843	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	06/24/2020	22,551	06/24/2020	96,443	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	01/08/2020	8,565	01/08/2020	59,330	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)		13,986		37,113	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)		702,384		1,983,956	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		32,441		293,332	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		734,825		2,277,288	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1326

Period:

Worksheet E-1

Component CCN: 14-Z326

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
1/7/2021 8:31 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,437,218		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	06/24/2020	20,472		0	3.01
3.02		01/08/2020	21,083		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		41,555		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,478,773		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		14,951		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,493,724		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
1/7/2021 8:31 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1326

Period:

Worksheet E-2

Component CCN: 14-Z326

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/7/2021 8:31 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,859,029	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)		819,503	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		2,076	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,678,532	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,678,532	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2,678,532	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		142,456	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		2,536,076	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		2,536,076	0	19.00
19.01	Sequestration adjustment (see instructions)		42,352	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		2,478,773	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)		14,951	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: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 1/7/2021 8:31 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		902,836	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)		902,836	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		911,864	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)		911,864	19.00
20.00	Deductibles (exclude professional component)		212,137	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		699,727	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		699,727	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		73,197	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		47,578	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		73,197	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		747,305	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)		747,305	30.00
30.01	Sequestration adjustment (see instructions)		12,480	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		702,384	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)		32,441	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: 14-1326

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

Worksheet G

Date/Time Prepared:
1/7/2021 8:31 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	8,386,175	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	1,988,006	0	0	0	4.00
5.00	Other receivable	8,309	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	427,496	0	0	0	7.00
8.00	Prepaid expenses	161,072	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)	10,971,058	0	0	0	11.00
FIXED ASSETS						
12.00	Land	69,760	0	0	0	12.00
13.00	Land improvements	499,729	0	0	0	13.00
14.00	Accumulated depreciation	-325,852	0	0	0	14.00
15.00	Buildings	21,739,093	0	0	0	15.00
16.00	Accumulated depreciation	-13,114,041	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	7,929,288	0	0	0	19.00
20.00	Accumulated depreciation	-6,095,426	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	536,531	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,239,082	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,204,757	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	104,262	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,309,019	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,519,159	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,028,152	0	0	0	37.00
38.00	Salaries, wages, and fees payable	644,474	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	670,000	0	0	0	40.00
41.00	Deferred income	4,035,175	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	248,072	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,625,873	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	18,090,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,090,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24,715,873	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	803,286	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	803,286	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,519,159	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1326

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

Worksheet G-1

Date/Time Prepared:
1/7/2021 8:31 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		441,775		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		361,511				2.00
3.00	Total (sum of line 1 and line 2)		803,286		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		803,286		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)		803,286		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1326

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
1/7/2021 8:31 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	972,595		972,595	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	2,202,750		2,202,750	5.00
6.00	Swing bed - NF	200,695		200,695	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)	3,376,040		3,376,040	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)	3,376,040		3,376,040	17.00
18.00	Ancillary services	4,702,788	18,551,652	23,254,440	18.00
19.00	Outpatient services	84	3,261,583	3,261,667	19.00
20.00	RURAL HEALTH CLINIC	0	1,221,653	1,221,653	20.00
20.01	RURAL HEALTH CLINIC II	0	528,354	528,354	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL CHARGES	275,471	273,217	548,688	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,354,383	23,836,459	32,190,842	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,754,335		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	INTEREST EXPENSE	896,903			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)		896,903		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		15,857,432		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1326

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

Worksheet G-3

Date/Time Prepared:
1/7/2021 8:31 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	32,190,842	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,690,411	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,500,431	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,857,432	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-357,001	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	85,286	6.00
7.00	Income from investments	62,183	7.00
8.00	Revenues from telephone and other miscellaneous communication services	137	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	500	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	2,531	16.00
17.00	Revenue from sale of drugs to other than patients	6,871	17.00
18.00	Revenue from sale of medical records and abstracts	2,079	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	1,014	21.00
22.00	Rental of hospital space	41,891	22.00
23.00	Governmental appropriations	649,655	23.00
24.00	340B DRUG REVENUE	607,845	24.00
24.01	WELLNESS PROGRAMS	54,397	24.01
24.02	MISCELLANEOUS INCOME	16,886	24.02
24.50	COVID-19 PHE Funding	84,140	24.50
25.00	Total other income (sum of lines 6-24)	1,615,415	25.00
26.00	Total (line 5 plus line 25)	1,258,414	26.00
27.00	INTEREST EXPENSE	896,903	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	896,903	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	361,511	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period:

Worksheet M-1

Component CCN: 14-3477

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/7/2021 8:31 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	190,692	0	190,692	0	190,692 1.00
2.00	Physician Assistant	98,000	0	98,000	0	98,000 2.00
3.00	Nurse Practitioner	210,625	0	210,625	-1,458	209,167 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	146,710	0	146,710	0	146,710 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	113,120	113,120 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)	646,027	0	646,027	111,662	757,689 10.00
11.00	Physician Services Under Agreement	0	0	0	409,381	409,381 11.00
12.00	Physician Supervision Under Agreement	0	0	0	7,450	7,450 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	416,831	416,831 14.00
15.00	Medical Supplies	0	42,811	42,811	0	42,811 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	42,811	42,811	0	42,811 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	646,027	42,811	688,838	528,493	1,217,331 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	1,458	1,458 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	1,458	1,458 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	200	200	0	200 29.00
30.00	Administrative Costs	103,095	559,597	662,692	-535,254	127,438 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	103,095	559,797	662,892	-535,254	127,638 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	749,122	602,608	1,351,730	-5,303	1,346,427 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period:

Worksheet M-1

Component CCN: 14-3477

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

Date/Time Prepared:

1/7/2021 8:31 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	190,692	1.00
2.00	Physician Assistant	0	98,000	2.00
3.00	Nurse Practitioner	0	209,167	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	146,710	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	113,120	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	757,689	10.00
11.00	Physician Services Under Agreement	0	409,381	11.00
12.00	Physician Supervision Under Agreement	0	7,450	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	416,831	14.00
15.00	Medical Supplies	0	42,811	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	42,811	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,217,331	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	1,458	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,458	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	200	29.00
30.00	Administrative Costs	0	127,438	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	127,638	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,346,427	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period:

Worksheet M-1

Component CCN: 14-8529

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/7/2021 8:31 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	254,620	0	254,620	-1,191	253,429 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	71,808	0	71,808	0	71,808 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)	326,428	0	326,428	-1,191	325,237 10.00
11.00	Physician Services Under Agreement	0	0	0	57,098	57,098 11.00
12.00	Physician Supervision Under Agreement	0	82,754	82,754	-76,754	6,000 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	82,754	82,754	-19,656	63,098 14.00
15.00	Medical Supplies	0	5,676	5,676	0	5,676 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,676	5,676	0	5,676 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	326,428	88,430	414,858	-20,847	394,011 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	1,191	1,191 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	1,191	1,191 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	113,331	113,331	-112,843	488 29.00
30.00	Administrative Costs	65,221	21,144	86,365	19,656	106,021 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	65,221	134,475	199,696	-93,187	106,509 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	391,649	222,905	614,554	-112,843	501,711 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1326

Period:

Worksheet M-1

Component CCN: 14-8529

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

Date/Time Prepared:

1/7/2021 8:31 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	253,429	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	71,808	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	325,237	10.00
11.00	Physician Services Under Agreement	0	57,098	11.00
12.00	Physician Supervision Under Agreement	0	6,000	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	63,098	14.00
15.00	Medical Supplies	0	5,676	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,676	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	394,011	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	1,191	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,191	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	488	29.00
30.00	Administrative Costs	0	106,021	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	106,509	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	501,711	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1326

Period:

Worksheet M-2

Component CCN: 14-3477

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

Date/Time Prepared:

1/7/2021 8:31 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.30	3,323	4,200	5,460		1.00
2.00	Physician Assistant	0.49	1,211	2,100	1,029		2.00
3.00	Nurse Practitioner	1.13	3,157	2,100	2,373		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.92	7,691		8,862	8,862	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.56	1,557			1,557	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)	3.48	9,248			10,419	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,217,331	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,458	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,218,789	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998804	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					127,638	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					774,664	15.00
16.00	Total overhead (sum of lines 14 and 15)					902,302	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					902,302	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					901,223	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,118,554	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1326

Period:

Worksheet M-2

Component CCN: 14-8529

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

Date/Time Prepared:

1/7/2021 8:31 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.17	273	4,200	714		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.76	3,829	2,100	3,696		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.93	4,102		4,410	4,410	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)	1.93	4,102			4,410	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)					394,011	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					1,191	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					395,202	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.996986	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					106,509	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					323,031	15.00
16.00	Total overhead (sum of lines 14 and 15)					429,540	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					429,540	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					428,245	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					822,256	20.00

Health Financial Systems		HAMILTON MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-3477		Date/Time Prepared: 1/7/2021 8:31 am	
		Title XVIII	RHC I	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,118,554	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			29,150	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,089,404	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,419	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)			10,419	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			200.54	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)			0.00	8.00
9.00	Rate for Program covered visits (see instructions)			200.54	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)			0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			574,748	11.00
12.00	Program covered visits for mental health services (from contractor records)			340	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			68,184	13.00
14.00	Limit adjustment for mental health services (see instructions)			68,184	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) *			642,932	16.00
16.01	Total program charges (see instructions)(from contractor's records)			448,207	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,032	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,915	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.)			468,299	16.04
16.05	Total program cost (see instructions)			0	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			54,643	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			78,307	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			471,214	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			10,722	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			481,936	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)			481,936	26.00
26.01	Sequestration adjustment (see instructions)			8,048	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			469,414	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			4,474	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		HAMILTON MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1326	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-8529		Date/Time Prepared: 1/7/2021 8:31 am	
		Title XVIII	RHC II	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			822,256	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			5,831	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			816,425	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,410	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)			4,410	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			185.13	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		185.13	185.13	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	204	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	37,767	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	37,767	16.00
16.01	Total program charges (see instructions)(from contractor's records)			24,705	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			205	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			313	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.)			26,446	16.04
16.05	Total program cost (see instructions)		0	26,759	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			4,396	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			4,021	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			26,759	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			2,406	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			29,165	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)			29,165	26.00
26.01	Sequestration adjustment (see instructions)			487	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			18,853	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)			9,825	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: 14-1326 Component CCN: 14-3477	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 1/7/2021 8:31 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		757,689	757,689	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000604	0.003794	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		458	2,875	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		6,418	6,999	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		6,876	9,874	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,217,331	1,217,331	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		901,223	901,223	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.005648	0.008111	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		5,090	7,310	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		11,966	17,184	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		68	427	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		175.97	40.24	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		28	144	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		4,927	5,795	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)			29,150	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)			10,722	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1326 Component CCN: 14-8529	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 1/7/2021 8:31 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		325,237	325,237	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000058	0.002118	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		19	689	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		283	1,803	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		302	2,492	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		394,011	394,011	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		428,245	428,245	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000766	0.006325	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		328	2,709	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		630	5,201	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		3	110	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		210.00	47.28	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		2	42	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		420	1,986	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)			5,831	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			2,406	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1326 Component CCN: 14-3477	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 1/7/2021 8:31 am	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			450,549	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			01/08/2020	1,772	3.01
3.02			06/24/2020	17,093	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)			18,865	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			469,414	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			4,474	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			473,888	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1326 Component CCN: 14-8529	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 1/7/2021 8:31 am	
			RHC II	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		18,610	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		06/24/2020	243	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)		243	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		18,853	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		9,825	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		28,678	7.00	
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00