

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: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/21/2020 10:06 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date:	Time:
	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 HARDIN COUNTY GENERAL HOSPITAL (14-1328) for the cost reporting period beginning 04/01/2019 and ending 03/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

ADMINISTRATOR

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-81,948	61,267	0	-204,883	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	-185,285	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		65,309		0	10.00
200.00	Total	0	-267,233	126,576	0	-204,883	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: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/21/2020 10:06 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 6 FERRELL ROAD			PO Box: 2467				1.00	
2.00	City: ROSICLARE			State: IL		Zip Code: 62982		County: HARDIN 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		HARDIN COUNTY GENERAL HOSPITAL	141328	99914	1	07/09/2003	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		HARDIN COUNTY SWING BED	14Z328	99914		07/09/2003	N	O
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		HARDIN COUNTY RHC	143479	99914		04/03/2006	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2019	03/31/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/21/2020 10:06 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		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
Date/Time Prepared:
8/21/2020 10:06 am

	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: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
Date/Time Prepared:
8/21/2020 10:06 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.					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)					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.					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)					76.00

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			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	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/21/2020 10:06 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		0115.00
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:	44,243	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/21/2020 10:06 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/21/2020 10:06 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/30/2020	Y	04/30/2020
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: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/21/2020 10:06 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	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARK	DALLAS	41.00
42.00	Enter the employer/company name of the cost report preparer.	KERBER, ECK & BRAECKEL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-529-1040	MARKD@KEBCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/21/2020 10:06 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.	PARTNER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

Health Financial Systems		HARDIN COUNTY GENERAL HOSPITAL		Non-CMS HFS Worksheet	
HFS Supplemental Information		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part IX Date/Time Prepared: 8/21/2020 10:06 am	
			Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	N	N		1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	N		2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	N		3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N		3.01
			Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N		4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N		5.00
			Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	N	N		6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	N	N		7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N		8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N		9.00
			State 1.00		
STATE MEDICAID FORMS					
10.00	Select the state when using state Medicaid forms.				10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/21/2020 10:06 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	32,448.00	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	32,448.00	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	32,448.00	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
26.25 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: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/21/2020 10:06 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)	899	50	1,352			1.00
2.00	HMO and other (see instructions)	115	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,188	0	1,341			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	47			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,087	50	2,740			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)	2,087	50	2,740	0.00	102.42	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	3,993	0	10,500	0.00	19.28	26.00
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	121.70	27.00
28.00	Observation Bed Days		14	455			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: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/21/2020 10:06 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	261	8	374	1.00
2.00 HMO and other (see instructions)			24	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	261	8	374	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
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		HARDIN COUNTY GENERAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1328 Component CCN: 14-3479		Period: From 04/01/2019 To 03/31/2020 Worksheet S-8 Date/Time Prepared: 8/21/2020 10:06 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	6 FERRELL ROAD		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ROSI CLARE		IL 62982	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	09:00		17:00	09:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			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	HARDIN		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	09:00	17:00	09:00
		17:00		09:00	17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1328 Component CCN: 14-3479	Period: From 04/01/2019 To 03/31/2020	Worksheet S-8 Date/Time Prepared: 8/21/2020 10:06 am	
			RHC I		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	09:00	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1328

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

Worksheet S-10

Date/Time Prepared:
8/21/2020 10:06 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)		0.556761	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		708,499	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		1,306,828	5.00
6.00	Medicaid charges		4,384,406	6.00
7.00	Medicaid cost (line 1 times line 6)		2,441,066	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)		425,739	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		425,739	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	140,063	547,708	687,771
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	77,982	547,708	625,690
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)	77,982	547,708	625,690
			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)		724,121	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		267,850	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		412,076	27.01
28.00	Non-Medicare bad debt expense (see instructions)		312,045	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		317,960	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		943,650	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,369,389	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1328

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

Worksheet A

Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati 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		82,337	82,337	8,883	91,220	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		129,215	129,215	5,814	135,029	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	44,000	44,000	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	803,849	1,758,613	2,562,462	-48,434	2,514,028	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	193,740	223,835	417,575	-8,264	409,311	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,402	12,382	58,784	0	58,784	8.00
9.00	00900	HOUSEKEEPING	121,157	36,808	157,965	0	157,965	9.00
10.00	01000	DIETARY	115,109	126,723	241,832	-53,664	188,168	10.00
11.00	01100	CAFETERIA	0	0	0	53,137	53,137	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	106,696	106,696	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	32,998	7,928	40,926	-31,490	9,436	14.00
15.00	01500	PHARMACY	77,152	202,625	279,777	-70,664	209,113	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	166,018	94,467	260,485	0	260,485	16.00
17.00	01700	SOCIAL SERVICE	27,828	5,569	33,397	0	33,397	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,036,911	496,782	1,533,693	-242,727	1,290,966	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	381,178	293,441	674,619	-6,114	668,505	54.00
60.00	06000	LABORATORY	401,005	710,061	1,111,066	936	1,112,002	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	53,820	52,926	106,746	-46,218	60,528	65.00
66.00	06600	PHYSICAL THERAPY	111,248	90,099	201,347	-602	200,745	66.00
69.00	06900	ELECTROCARDIOLOGY	8,157	853	9,010	22,570	31,580	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	116,991	116,991	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	285,589	285,589	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,261,210	285,055	1,546,265	7,987	1,554,252	88.00
90.00	09000	CLINIC	106,964	67,619	174,583	12,217	186,800	90.00
91.00	09100	EMERGENCY	1,243,122	228,850	1,471,972	-133,072	1,338,900	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		23,571	23,571	-23,571	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,187,868	4,929,759	11,117,627	0	11,117,627	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
200.00		TOTAL (SUM OF LINES 118 through 199)	6,187,868	4,929,759	11,117,627	0	11,117,627	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet A
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	91,220	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-56,579	78,450	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	44,000	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-366,255	2,147,773	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	409,311	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	58,784	8.00
9.00	00900	HOUSEKEEPING	0	157,965	9.00
10.00	01000	DIETARY	0	188,168	10.00
11.00	01100	CAFETERIA	-2,891	50,246	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	106,696	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,436	14.00
15.00	01500	PHARMACY	0	209,113	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,262	258,223	16.00
17.00	01700	SOCIAL SERVICE	0	33,397	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-104,857	1,186,109	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	668,505	54.00
60.00	06000	LABORATORY	0	1,112,002	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	60,528	65.00
66.00	06600	PHYSICAL THERAPY	0	200,745	66.00
69.00	06900	ELECTROCARDIOLOGY	0	31,580	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	116,991	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	285,589	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,554,252	88.00
90.00	09000	CLINIC	0	186,800	90.00
91.00	09100	EMERGENCY	-480,175	858,725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,013,019	10,104,608	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VENDING MACHINE	0	0	190.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,013,019	10,104,608	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet Non-CMS W
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
12.00	MAINTENANCE OF PERSONNEL	01200		12.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
20.00	NURSING SCHOOL	02000		20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	02100		21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	02200		22.00
23.00	PARAMEDICAL EDU PROG	02300		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
62.30	BLOOD CLOTTING FOR HEMOPHILIACS	06250		62.30
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
93.99	PARTIAL HOSPITALIZATION PROGRAM	09399		93.99
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.01	VENDING MACHINE	19001		190.01
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-1328

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

Worksheet A-6

Date/Time Prepared:
8/21/2020 10:06 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS SUPPLY COST FROM CS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	24,749	6,741	1.00	
	TOTALS		24,749	6,741		
	B - TO RECLASS DON COST					
1.00	NURSING ADMINISTRATION	13.00	88,972	17,724	1.00	
	TOTALS		88,972	17,724		
	D - TO RECLASS SUPPLY COST					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	85,501	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	
	TOTALS		0	85,501		
	E - TO RECLASS INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,244	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,767	2.00	
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44,000	3.00	
	TOTALS		0	60,011		
	F - TO RECLASS INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,072	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	11,577	2.00	
3.00	RURAL HEALTH CLINIC	88.00	0	1,554	3.00	
4.00	LABORATORY	60.00	0	1,368	4.00	
	TOTALS		0	23,571		
	G - TO RECLASS CAFE COST					
1.00	CAFETERIA	11.00	25,324	27,813	1.00	
	TOTALS		25,324	27,813		
	H - TO RECLASS CARDIAC MONITORING COST					
1.00	ELECTROCARDIOLOGY	69.00	19,084	3,486	1.00	
	TOTALS		19,084	3,486		
	I - TO RECLASS DRUG COST					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	285,589	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
	TOTALS		0	285,589		
	J - TO RECLASS CLINIC DEPRECIATION					
1.00	RURAL HEALTH CLINIC	88.00	0	6,433	1.00	
2.00	CLINIC	90.00	0	3,953	2.00	
	TOTALS		0	10,386		
	K - TO RECLASS CLINIC COST					
1.00	CLINIC	90.00	6,742	1,522	1.00	
	TOTALS		6,742	1,522		
500.00	Grand Total: Increases		164,871	522,344	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1328

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

Worksheet A-6

Date/Time Prepared:
8/21/2020 10:06 am

	Decreases						8/21/2020 10:06 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS SUPPLY COST FROM CS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	24,749	6,741	0		1.00
	TOTALS		24,749	6,741			
	B - TO RECLASS DON COST						
1.00	ADULTS & PEDIATRICS	30.00	88,972	17,724	0		1.00
	TOTALS		88,972	17,724			
	D - TO RECLASS SUPPLY COST						
1.00	ADULTS & PEDIATRICS	30.00	0	19,698	0		1.00
2.00	EMERGENCY	91.00	0	13,011	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,114	0		3.00
4.00	LABORATORY	60.00	0	432	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	46,218	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	28	0		6.00
	TOTALS		0	85,501			
	E - TO RECLASS INSURANCE EXPENSE						
1.00		0.00	0	0	12		1.00
2.00		0.00	0	0	12		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	60,011	0		3.00
	TOTALS		0	60,011			
	F - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	23,571	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	23,571			
	G - TO RECLASS CAFE COST						
1.00	DIETARY	10.00	25,324	27,813	0		1.00
	TOTALS		25,324	27,813			
	H - TO RECLASS CARDIAC MONITORING COST						
1.00	ADULTS & PEDIATRICS	30.00	19,084	3,486	0		1.00
	TOTALS		19,084	3,486			
	I - TO RECLASS DRUG COST						
1.00	ADULTS & PEDIATRICS	30.00	0	93,763	0		1.00
2.00	EMERGENCY	91.00	0	120,061	0		2.00
3.00	PHARMACY	15.00	0	70,664	0		3.00
4.00	DIETARY	10.00	0	527	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	574	0		5.00
	TOTALS		0	285,589			
	J - TO RECLASS CLINIC DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,433	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,953	9		2.00
	TOTALS		0	10,386			
	K - TO RECLASS CLINIC COST						
1.00	OPERATION OF PLANT	7.00	6,742	1,522	0		1.00
	TOTALS		6,742	1,522			
500.00	Grand Total: Decreases		164,871	522,344			500.00

RECLASSIFICATIONS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/21/2020 10:06 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - TO RECLASS SUPPLY COST FROM CS									
1.00	MEDICAL SUPPLIES	71.00	24,749	6,741	CENTRAL SERVICES &	14.00	24,749	6,741	1.00
	CHARGED TO PATIENT				SUPPLY				
	TOTALS		24,749	6,741	TOTALS		24,749	6,741	
B - TO RECLASS DON COST									
1.00	NURSING	13.00	88,972	17,724	ADULTS & PEDIATRICS	30.00	88,972	17,724	1.00
	ADMINISTRATION								
	TOTALS		88,972	17,724	TOTALS		88,972	17,724	
D - TO RECLASS SUPPLY COST									
1.00	MEDICAL SUPPLIES	71.00	0	85,501	ADULTS & PEDIATRICS	30.00	0	19,698	1.00
	CHARGED TO PATIENT								
2.00		0.00	0	0	EMERGENCY	91.00	0	13,011	2.00
3.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	6,114	3.00
4.00		0.00	0	0	LABORATORY	60.00	0	432	4.00
5.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	46,218	5.00
6.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	28	6.00
	TOTALS		0	85,501	TOTALS		0	85,501	
E - TO RECLASS INSURANCE EXPENSE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,244		0.00	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,767		0.00	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44,000	ADMINISTRATIVE & GENERAL	5.00	0	60,011	3.00
	TOTALS		0	60,011	TOTALS		0	60,011	
F - TO RECLASS INTEREST									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,072	INTEREST EXPENSE	113.00	0	23,571	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	11,577		0.00	0	0	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	1,554		0.00	0	0	3.00
4.00	LABORATORY	60.00	0	1,368		0.00	0	0	4.00
	TOTALS		0	23,571	TOTALS		0	23,571	
G - TO RECLASS CAFE COST									
1.00	CAFETERIA	11.00	25,324	27,813	DIETARY	10.00	25,324	27,813	1.00
	TOTALS		25,324	27,813	TOTALS		25,324	27,813	
H - TO RECLASS CARDIAC MONITORING COST									
1.00	ELECTROCARDIOLOGY	69.00	19,084	3,486	ADULTS & PEDIATRICS	30.00	19,084	3,486	1.00
	TOTALS		19,084	3,486	TOTALS		19,084	3,486	
I - TO RECLASS DRUG COST									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	285,589	ADULTS & PEDIATRICS	30.00	0	93,763	1.00
2.00		0.00	0	0	EMERGENCY	91.00	0	120,061	2.00
3.00		0.00	0	0	PHARMACY	15.00	0	70,664	3.00
4.00		0.00	0	0	DIETARY	10.00	0	527	4.00
5.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	574	5.00
	TOTALS		0	285,589	TOTALS		0	285,589	
J - TO RECLASS CLINIC DEPRECIATION									
1.00	RURAL HEALTH CLINIC	88.00	0	6,433	CAP REL COSTS-BLDG & FIXT	1.00	0	6,433	1.00
2.00	CLINIC	90.00	0	3,953	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,953	2.00
	TOTALS		0	10,386	TOTALS		0	10,386	
K - TO RECLASS CLINIC COST									
1.00	CLINIC	90.00	6,742	1,522	OPERATION OF PLANT	7.00	6,742	1,522	1.00
	TOTALS		6,742	1,522	TOTALS		6,742	1,522	
500.00	Grand Total: Increases		164,871	522,344	Grand Total: Decreases		164,871	522,344	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part I
Date/Time Prepared:
8/21/2020 10:06 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	17,000	0	0	0	0	1.00	
2.00	Land Improvements	256,674	0	0	0	0	2.00	
3.00	Buildings and Fixtures	1,796,754	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	2,833,634	267,786	0	267,786	0	6.00	
7.00	HIT designated Assets	898,160	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	5,802,222	267,786	0	267,786	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	5,802,222	267,786	0	267,786	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	17,000	0				1.00	
2.00	Land Improvements	256,674	0				2.00	
3.00	Buildings and Fixtures	1,796,754	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	3,101,420	0				6.00	
7.00	HIT designated Assets	898,160	0				7.00	
8.00	Subtotal (sum of lines 1-7)	6,070,008	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	6,070,008	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part II
Date/Time Prepared:
8/21/2020 10:06 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	82,337	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	129,215	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	211,552	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	82,337				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	129,215				2.00
3.00	Total (sum of lines 1-2)	0	211,552				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part III
Date/Time Prepared:
8/21/2020 10:06 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	2,070,428	0	2,070,428	0.341091	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,999,580	0	3,999,580	0.658909	0	2.00
3.00	Total (sum of lines 1-2)	6,070,008	0	6,070,008	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	75,904	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	68,683	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	144,587	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	9,072	6,244	0	0	91,220	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,767	0	0	78,450	2.00
3.00	Total (sum of lines 1-2)	9,072	16,011	0	0	169,670	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1328

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

Worksheet A-8

Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP 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)	B	-69,661	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,134	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-585,032			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	-2,891	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	A	-2,262	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-56,579	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1328

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

Worksheet A-8

Date/Time Prepared:
8/21/2020 10:06 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	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	LOBBYING	A	0	ADMINISTRATIVE & GENERAL	5.00	0	34.00
40.00	LATE FEES	A	-8,550	ADMINISTRATIVE & GENERAL	5.00	0	40.00
42.00	PROVIDER TAX	A	-277,772	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	LOBBING PORTION OF DUES	A	-7,138	ADMINISTRATIVE & GENERAL	5.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,013,019				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: 14-1328

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

Worksheet A-8-2

Date/Time Prepared:
8/21/2020 10:06 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	5.00	ADMINISTRATIVE & GENERAL	31,971	0	31,971	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	104,857	104,857	0	0	0	2.00
3.00	60.00	AGGREGATE-LABORATORY	106,550	0	106,550	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	1,054,403	480,175	574,228	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,297,781	585,032	712,749		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	104,857		2.00
3.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	91.00	AGGREGATE-EMERGENCY	0	0	0	480,175		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	585,032		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/21/2020 10:06 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.00	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	350.95	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.03	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.52	41.52	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)					29,139	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)					29,139	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)					29,139	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					83.03	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					64,763	22.00
23.00	Total salary equivalency (see instructions)					64,763	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)					0	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)					0	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)					0	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)					0	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: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/21/2020 10:06 am	
				Physical Therapy		Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.03	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)					64,763	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					64,763	63.00
64.00	Total cost of outside supplier services (from your records)					21,059	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					0	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					0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/21/2020 10:06 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.00	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	681.96	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.69	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)	39.35	39.35	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)					53,663	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)					53,663	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)					53,663	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)					78.69	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					61,378	22.00
23.00	Total salary equivalency (see instructions)					61,378	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)					0	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)					0	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)					0	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)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/21/2020 10:06 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.69	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)					61,378	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	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)					61,378	63.00
64.00	Total cost of outside supplier services (from your records)					40,917	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					0	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					0	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/21/2020 10:06 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)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.00	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	359.35	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	75.61	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)	37.81	37.81	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)						27,170	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)						27,170	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)						27,170	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)						75.61	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						58,976	22.00
23.00	Total salary equivalency (see instructions)						58,976	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)						0	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)						0	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)						0	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)						0	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: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/21/2020 10:06 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)	75.61	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)						58,976	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	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)						58,976	63.00
64.00	Total cost of outside supplier services (from your records)						21,562	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						0	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						0	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: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	91,220	91,220			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	78,450		78,450		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	44,000	0	0	44,000	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,147,773	12,556	10,798	5,716	2,176,843
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	409,311	7,273	6,255	1,330	424,169
8.00	00800	LAUNDRY & LINEN SERVICE	58,784	3,279	2,820	330	65,213
9.00	00900	HOUSEKEEPING	157,965	0	0	862	158,827
10.00	01000	DIETARY	188,168	3,228	2,776	638	194,810
11.00	01100	CAFETERIA	50,246	1,366	1,175	180	52,967
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	106,696	7,173	6,169	633	120,671
14.00	01400	CENTRAL SERVICES & SUPPLY	9,436	0	0	59	9,495
15.00	01500	PHARMACY	209,113	1,435	1,234	549	212,331
16.00	01600	MEDICAL RECORDS & LIBRARY	258,223	3,894	3,349	1,181	266,647
17.00	01700	SOCIAL SERVICE	33,397	640	551	198	34,786
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,186,109	15,607	13,422	6,605	1,221,743
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	668,505	4,791	4,120	2,711	680,127
60.00	06000	LABORATORY	1,112,002	1,825	1,569	2,852	1,118,248
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	60,528	1,435	1,234	383	63,580
66.00	06600	PHYSICAL THERAPY	200,745	2,790	2,399	791	206,725
69.00	06900	ELECTROCARDIOLOGY	31,580	0	0	194	31,774
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	116,991	1,375	1,182	176	119,724
73.00	07300	DRUGS CHARGED TO PATIENTS	285,589	0	0	0	285,589
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,554,252	15,973	13,737	8,963	1,592,925
90.00	09000	CLINIC	186,800	2,049	1,763	809	191,421
91.00	09100	EMERGENCY	858,725	3,902	3,356	8,840	874,823
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,104,608	90,591	77,909	44,000	10,103,438
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	344	296	0	640
190.01	19001	VENDING MACHINE	0	285	245	0	530
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	10,104,608	91,220	78,450	44,000	10,104,608

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,176,843					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	116,470	0	540,639			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,907	0	31,877	114,997		8.00
9.00	00900	HOUSEKEEPING	43,612	0	0	5,175	207,614	9.00
10.00	01000	DIETARY	53,492	0	31,379	4,267	12,805	10.00
11.00	01100	CAFETERIA	14,544	0	13,282	0	5,420	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	33,134	0	70,008	0	28,569	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,607	0	0	0	0	14.00
15.00	01500	PHARMACY	58,303	0	13,946	0	5,691	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	73,217	0	37,854	0	15,447	16.00
17.00	01700	SOCIAL SERVICE	9,552	0	6,226	0	2,541	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	335,472	0	151,722	70,126	61,915	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,753	0	46,571	7,415	19,004	54.00
60.00	06000	LABORATORY	307,054	0	21,030	0	8,582	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	17,458	0	13,946	0	5,691	65.00
66.00	06600	PHYSICAL THERAPY	56,764	0	27,118	6,267	11,066	66.00
69.00	06900	ELECTROCARDIOLOGY	8,725	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,874	0	13,365	0	5,454	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,418	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	437,391	0	0	0	0	88.00
90.00	09000	CLINIC	52,561	0	19,923	2,462	8,130	90.00
91.00	09100	EMERGENCY	240,213	0	36,277	19,285	14,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,176,521	0	534,524	114,997	205,119	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	176	0	3,348	0	1,366	190.00
190.01	19001	VENDING MACHINE	146	0	2,767	0	1,129	190.01
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)	2,176,843	0	540,639	114,997	207,614	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	296,753					10.00
11.00	01100	CAFETERIA	64,112	150,325				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,951	0	255,333		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	457	0	8,392	20,951	14.00
15.00	01500	PHARMACY	0	3,461	0	0	1,341	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,168	0	0	188	16.00
17.00	01700	SOCIAL SERVICE	0	1,300	0	0	16	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	217,276	42,988	0	246,941	1,275	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,159	0	0	147	54.00
60.00	06000	LABORATORY	0	17,023	0	0	13,937	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,020	0	0	139	65.00
66.00	06600	PHYSICAL THERAPY	0	4,076	0	0	37	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,616	0	0	39	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,388	0	0	2,727	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	33,870	0	0	591	88.00
90.00	09000	CLINIC	15,365	3,847	0	0	54	90.00
91.00	09100	EMERGENCY	0	14,001	0	0	460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	296,753	150,325	0	255,333	20,951	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
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)	296,753	150,325	0	255,333	20,951	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	295,073					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	400,521				16.00
17.00	01700	SOCIAL SERVICE	0	0	54,421			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	394,252	54,421	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,269	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	268,899	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	26,174	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	295,073	400,521	54,421	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
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)	295,073	400,521	54,421	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS		PARAMEDICAL EDU PROG	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMEDICAL EDU PROG			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	2,798,131	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	960,445	0	54.00
60.00	06000	LABORATORY	0	0	0	1,485,874	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	102,834	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	312,053	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	42,154	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	175,532	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	632,906	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,090,951	0	88.00
90.00	09000	CLINIC	0	0	0	293,763	0	90.00
91.00	09100	EMERGENCY	0	0	0	1,199,863	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	10,094,506	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	5,530	0	190.00
190.01	19001	VENDING MACHINE	0	0	0	4,572	0	190.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	10,104,608	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMEDICAL EDU PROG	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		2,798,131	
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		10,094,506	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	VENDING MACHINE	190.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		10,104,608	

COST ALLOCATION STATISTICS

Provider CCN: 14-1328

Period:

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

Worksheet Non-CMS W

Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALA RIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM COST	5.00
6.00	MAINTENANCE & REPAIRS	3	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	4	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	5	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	4	SQUARE FEET	9.00
10.00	DIETARY	6	MEALS SERV ED	10.00
11.00	CAFETERIA	7	FTE'S SERV ED	11.00
12.00	MAINTENANCE OF PERSONNEL	8	NUMBER HOUSED	12.00
13.00	NURSING ADMINISTRATION	9	DIRECT NRS ING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	10	COSTED REQ UIS.	14.00
15.00	PHARMACY	11	COSTED REQ UIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	12	TIME SPENT	16.00
17.00	SOCIAL SERVICE	13	PATIENT DA YS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	14	ASSIGNED TIME	19.00
20.00	NURSING SCHOOL	15	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	16	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	17	ASSIGNED TIME	22.00
23.00	PARAMEDICAL EDU PROG	18	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	12,556	10,798	23,354	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	7,273	6,255	13,528	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,279	2,820	6,099	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	9.00
10.00	01000	DIETARY	0	3,228	2,776	6,004	10.00
11.00	01100	CAFETERIA	0	1,366	1,175	2,541	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	7,173	6,169	13,342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,435	1,234	2,669	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,894	3,349	7,243	16.00
17.00	01700	SOCIAL SERVICE	0	640	551	1,191	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	15,607	13,422	29,029	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,791	4,120	8,911	54.00
60.00	06000	LABORATORY	0	1,825	1,569	3,394	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,435	1,234	2,669	65.00
66.00	06600	PHYSICAL THERAPY	0	2,790	2,399	5,189	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,375	1,182	2,557	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	15,973	13,737	29,710	88.00
90.00	09000	CLINIC	0	2,049	1,763	3,812	90.00
91.00	09100	EMERGENCY	0	3,902	3,356	7,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	90,591	77,909	168,500	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	344	296	640	190.00
190.01	19001	VENDING MACHINE	0	285	245	530	190.01
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	91,220	78,450	169,670	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,354					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,250	0	14,778			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	192	0	871	7,162		8.00
9.00	00900	HOUSEKEEPING	468	0	0	322	790	9.00
10.00	01000	DIETARY	574	0	858	266	49	10.00
11.00	01100	CAFETERIA	156	0	363	0	21	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	355	0	1,914	0	109	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28	0	0	0	0	14.00
15.00	01500	PHARMACY	626	0	381	0	22	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	786	0	1,035	0	59	16.00
17.00	01700	SOCIAL SERVICE	102	0	170	0	10	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,599	0	4,146	4,368	234	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,004	0	1,273	462	72	54.00
60.00	06000	LABORATORY	3,294	0	575	0	33	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	187	0	381	0	22	65.00
66.00	06600	PHYSICAL THERAPY	609	0	741	390	42	66.00
69.00	06900	ELECTROCARDIOLOGY	94	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	353	0	365	0	21	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	841	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,691	0	0	0	0	88.00
90.00	09000	CLINIC	564	0	545	153	31	90.00
91.00	09100	EMERGENCY	2,577	0	992	1,201	56	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,350	0	14,610	7,162	781	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2	0	92	0	5	190.00
190.01	19001	VENDING MACHINE	2	0	76	0	4	190.01
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)	23,354	0	14,778	7,162	790	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	7,751					10.00
11.00	01100	CAFETERIA	1,675	4,756				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	93	0	15,813		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14	0	520	562	14.00
15.00	01500	PHARMACY	0	109	0	0	36	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	227	0	0	5	16.00
17.00	01700	SOCIAL SERVICE	0	41	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,675	1,360	0	15,293	34	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	448	0	0	4	54.00
60.00	06000	LABORATORY	0	539	0	0	375	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	64	0	0	4	65.00
66.00	06600	PHYSICAL THERAPY	0	129	0	0	1	66.00
69.00	06900	ELECTROCARDIOLOGY	0	51	0	0	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	44	0	0	73	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,072	0	0	16	88.00
90.00	09000	CLINIC	401	122	0	0	1	90.00
91.00	09100	EMERGENCY	0	443	0	0	12	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,751	4,756	0	15,813	562	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
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)	7,751	4,756	0	15,813	562	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,843					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,355				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,514			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,209	1,514			30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	146	0			54.00
60.00	06000	LABORATORY	0	0	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,502	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	341	0	0			88.00
90.00	09000	CLINIC	0	0	0			90.00
91.00	09100	EMERGENCY	0	0	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,843	9,355	1,514	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
190.01	19001	VENDING MACHINE	0	0	0			190.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,843	9,355	1,514	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part II
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Cost Center Description			INTERNS & RESIDENTS		PARAMEDICAL EDU PROG	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMEDICAL EDU PROG			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				74,461	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC				13,320	0	54.00
60.00	06000	LABORATORY				8,210	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				3,327	0	65.00
66.00	06600	PHYSICAL THERAPY				7,101	0	66.00
69.00	06900	ELECTROCARDIOLOGY				146	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				3,413	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS				4,343	0	73.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				35,830	0	88.00
90.00	09000	CLINIC				5,629	0	90.00
91.00	09100	EMERGENCY				12,539	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	168,319	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				739	0	190.00
190.01	19001	VENDING MACHINE				612	0	190.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	169,670	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMEDICAL EDU PROG	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	VENDING MACHINE	190.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1328

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	32,047					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		32,047				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,187,868			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,411	4,411	803,849	-2,176,843	7,927,765	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,555	2,555	186,998	0	424,169	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,152	1,152	46,402	0	65,213	8.00
9.00	00900	HOUSEKEEPING	0	0	121,157	0	158,827	9.00
10.00	01000	DIETARY	1,134	1,134	89,785	0	194,810	10.00
11.00	01100	CAFETERIA	480	480	25,324	0	52,967	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,520	2,520	88,972	0	120,671	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	8,249	0	9,495	14.00
15.00	01500	PHARMACY	504	504	77,152	0	212,331	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,368	1,368	166,018	0	266,647	16.00
17.00	01700	SOCIAL SERVICE	225	225	27,828	0	34,786	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,483	5,483	928,855	0	1,221,743	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,683	1,683	381,178	0	680,127	54.00
60.00	06000	LABORATORY	641	641	401,005	0	1,118,248	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	504	504	53,820	0	63,580	65.00
66.00	06600	PHYSICAL THERAPY	980	980	111,248	0	206,725	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	27,241	0	31,774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	483	483	24,749	0	119,724	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	285,589	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,612	5,612	1,261,210	0	1,592,925	88.00
90.00	09000	CLINIC	720	720	113,706	0	191,421	90.00
91.00	09100	EMERGENCY	1,371	1,371	1,243,122	0	874,823	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,826	31,826	6,187,868	-2,176,843	7,926,595	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	121	121	0	0	640	190.00
190.01	19001	VENDING MACHINE	100	100	0	0	530	190.01
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)	91,220	78,450	44,000		2,176,843	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.846444	2.447967	0.007111		0.274585	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		23,354	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.002946	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: 14-1328

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERV ED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	19,538				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,152	74,282			8.00
9.00	00900	HOUSEKEEPING	0	0	3,343	18,386		9.00
10.00	01000	DIETARY	0	1,134	2,756	1,134	14,659	10.00
11.00	01100	CAFETERIA	0	480	0	480	3,167	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	2,530	0	2,530	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	504	0	504	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,368	0	1,368	0	16.00
17.00	01700	SOCIAL SERVICE	0	225	0	225	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	5,483	45,298	5,483	10,733	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,683	4,790	1,683	0	54.00
60.00	06000	LABORATORY	0	760	0	760	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	504	0	504	0	65.00
66.00	06600	PHYSICAL THERAPY	0	980	4,048	980	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	483	0	483	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	720	1,590	720	759	90.00
91.00	09100	EMERGENCY	0	1,311	12,457	1,311	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,317	74,282	18,165	14,659	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	121	0	121	0	190.00
190.01	19001	VENDING MACHINE	0	100	0	100	0	190.01
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)	0	540,639	114,997	207,614	296,753	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	27.671154	1.548114	11.291961	20.243741	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	14,778	7,162	790	7,751	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.756372	0.096416	0.042967	0.528754	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: 14-1328

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAFETERIA (FTE'S SERV ED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS.)	PHARMACY (COSTED REQ UIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,557					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	168	0	66,726			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26	0	2,193	656,900		14.00
15.00	01500	PHARMACY	197	0	0	42,057	313,388	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	408	0	0	5,900	0	16.00
17.00	01700	SOCIAL SERVICE	74	0	0	511	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,447	0	64,533	39,964	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	806	0	0	4,611	0	54.00
60.00	06000	LABORATORY	969	0	0	436,953	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	115	0	0	4,349	0	65.00
66.00	06600	PHYSICAL THERAPY	232	0	0	1,167	0	66.00
69.00	06900	ELECTROCARDIOLOGY	92	0	0	1,238	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	79	0	0	85,501	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	285,589	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,928	0	0	18,541	27,799	88.00
90.00	09000	CLINIC	219	0	0	1,690	0	90.00
91.00	09100	EMERGENCY	797	0	0	14,418	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,557	0	66,726	656,900	313,388	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
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)	150,325	0	255,333	20,951	295,073	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.567489	0.000000	3.826589	0.031894	0.941558	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,756	0	15,813	562	3,843	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.555802	0.000000	0.236984	0.000856	0.012263	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: 14-1328

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

Worksheet B-1

Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,750					16.00
17.00	01700	SOCIAL SERVICE	0	1,352				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMEDICAL EDU PROG	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,300	1,352	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	450	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,750	1,352	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	VENDING MACHINE	0	0	0	0	0	190.01
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)	400,521	54,421	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.931165	40.252219	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	9,355	1,514	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.325391	1.119822	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1328

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS	PARAMEDICAL EDU PROG (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMEDICAL EDU PROG		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	VENDING MACHINE	0	0	190.01
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)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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				Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE	Total Costs		
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	2,798,131		2,798,131	0	0	30.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	960,445		960,445	0	0	54.00	
60.00	06000	LABORATORY	1,485,874		1,485,874	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	102,834	0	102,834	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	312,053	0	312,053	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	42,154		42,154	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	175,532		175,532	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	632,906		632,906	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	2,090,951		2,090,951	0	0	88.00	
90.00	09000	CLINIC	293,763		293,763	0	0	90.00	
91.00	09100	EMERGENCY	1,199,863		1,199,863	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	403,594		403,594	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	10,498,100	0	10,498,100	0	0	200.00	
201.00		Less Observation Beds	403,594		403,594			201.00	
202.00		Total (see instructions)	10,094,506	0	10,094,506	0	0	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/21/2020 10:06 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	9.00	10.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,508,676		1,508,676			30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	546,990	4,369,057	4,916,047	0.195369	0.000000	54.00
60.00	06000	LABORATORY	663,023	3,447,084	4,110,107	0.361517	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	115,842	163,883	279,725	0.367625	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	369,936	644,646	1,014,582	0.307568	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	23,468	159,390	182,858	0.230529	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473,971	152,223	626,194	0.280316	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	876,605	960,099	1,836,704	0.344588	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,283,876	1,283,876			88.00
90.00	09000	CLINIC	0	370,510	370,510	0.792861	0.000000	90.00
91.00	09100	EMERGENCY	17,807	1,674,433	1,692,240	0.709038	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	309,248	309,248	1.305082	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,596,318	13,534,449	18,130,767			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,596,318	13,534,449	18,130,767			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/21/2020 10:06 am

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,798,131		2,798,131	0
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	960,445		960,445	0
60.00	06000	LABORATORY	1,485,874		1,485,874	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
65.00	06500	RESPIRATORY THERAPY	102,834	0	102,834	0
66.00	06600	PHYSICAL THERAPY	312,053	0	312,053	0
69.00	06900	ELECTROCARDIOLOGY	42,154		42,154	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	175,532		175,532	0
73.00	07300	DRUGS CHARGED TO PATIENTS	632,906		632,906	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,090,951		2,090,951	0
90.00	09000	CLINIC	293,763		293,763	0
91.00	09100	EMERGENCY	1,199,863		1,199,863	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	403,594		403,594	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	10,498,100	0	10,498,100	0
201.00		Less Observation Beds	403,594		403,594	0
202.00		Total (see instructions)	10,094,506	0	10,094,506	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0		30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	93.99
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	0	0	0		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	0	0	0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
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: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part II
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	13,320	4,916,047	0.002709	248,159	672	54.00
60.00	06000 LABORATORY	8,210	4,110,107	0.001998	328,471	656	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	3,327	279,725	0.011894	46,653	555	65.00
66.00	06600 PHYSICAL THERAPY	7,101	1,014,582	0.006999	42,163	295	66.00
69.00	06900 ELECTROCARDIOLOGY	146	182,858	0.000798	13,097	10	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,413	626,194	0.005450	180,457	983	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,343	1,836,704	0.002365	360,010	851	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	35,830	1,283,876	0.027908	0	0	88.00
90.00	09000 CLINIC	5,629	370,510	0.015193	0	0	90.00
91.00	09100 EMERGENCY	12,539	1,692,240	0.007410	17,806	132	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,740	309,248	0.034729	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00	Total (lines 50 through 199)	104,598	16,622,091		1,236,816	4,154	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1328

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

Worksheet D
Part IV
Date/Time Prepared:
8/21/2020 10:06 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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
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: 14-1328

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

Worksheet D
Part IV
Date/Time Prepared:
8/21/2020 10:06 am

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,916,047	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,110,107	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	279,725	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,014,582	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	182,858	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	626,194	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,836,704	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,283,876	0.000000	88.00
90.00	09000	CLINIC	0	0	0	370,510	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,692,240	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	309,248	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	16,622,091		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/21/2020 10:06 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	248,159	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	328,471	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	46,653	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	42,163	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	13,097	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	180,457	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	360,010	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	17,806	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		1,236,816	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020	Worksheet D Part IV Date/Time Prepared: 8/21/2020 10:06 am
			Title XVIII		Hospital	Cost
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
60.00	06000	LABORATORY	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99	
200.00		Total (lines 50 through 199)	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/21/2020 10:06 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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195369	0	1,620,785	0	0	0	54.00
60.00	06000	LABORATORY	0.361517	0	1,556,549	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.367625	0	24,900	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.307568	0	183,865	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.230529	0	155,495	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.280316	0	77,157	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344588	0	452,571	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0			0	0	88.00
90.00	09000	CLINIC	0.792861	0	359,837	0	0	0	90.00
91.00	09100	EMERGENCY	0.709038	0	687,557	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.305082	0	134,134	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	5,252,850	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	5,252,850	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/21/2020 10:06 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					
54.00	05400	RADIOLOGY-DIAGNOSTIC	316,651	0		54.00
60.00	06000	LABORATORY	562,719	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	9,154	0		65.00
66.00	06600	PHYSICAL THERAPY	56,551	0		66.00
69.00	06900	ELECTROCARDIOLOGY	35,846	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,628	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,951	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	285,301	0		90.00
91.00	09100	EMERGENCY	487,504	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	175,056	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	2,106,361	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,106,361	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part I
Date/Time Prepared:
8/21/2020 10:06 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	74,461	31,808	42,653	1,807	23.60	30.00
200.00	Total (lines 30 through 199)	74,461		42,653	1,807		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	50	1,180				30.00
200.00	Total (lines 30 through 199)	50	1,180				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part II
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	13,320	0	0.000000	0	0	54.00
60.00	06000 LABORATORY	8,210	0	0.000000	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	3,327	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	7,101	0	0.000000	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	146	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,413	0	0.000000	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,343	0	0.000000	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	35,830	0	0.000000	0	0	88.00
90.00	09000 CLINIC	5,629	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	12,539	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	10,740	0	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00	Total (lines 50 through 199)	104,598	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part III Date/Time Prepared: 8/21/2020 10:06 am	
					Title XIX		Hospital		Cost	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,807	0.00	50	30.00	
200.00		Total (lines 30 through 199)	0	0	0	1,807		50	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0				30.00	
200.00		Total (lines 30 through 199)	0	0	0				200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1328

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

Worksheet D
Part IV
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		Title XIX		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
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: 14-1328

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

Worksheet D
Part IV
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description			Title XIX		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description			Title XIX		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1328		Period: From 04/01/2019 To 03/31/2020	Worksheet D Part IV Date/Time Prepared: 8/21/2020 10:06 am
			Title XIX		Hospital	Cost
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
60.00	06000	LABORATORY	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99	
200.00		Total (lines 50 through 199)	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet D-1 Date/Time Prepared: 8/21/2020 10:06 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)		3,195	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,807	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,352	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,005	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)		336	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		35	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)		12	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		899	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)		891	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)		297	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		120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,798,131	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)		4,222	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)		1,574	25.00
26.00	Total swing-bed cost (see instructions)		1,195,290	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,602,841	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,602,841	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)		887.02	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		797,431	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)		797,431	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1328

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					387,634	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,185,065	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)					790,335	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					263,445	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,053,780	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)					455	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					887.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					403,594	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1328

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	74,461	2,798,131	0.026611	403,594	10,740	90.00
91.00	Nursing School cost	0	2,798,131	0.000000	403,594	0	91.00
92.00	Allied health cost	0	2,798,131	0.000000	403,594	0	92.00
93.00	All other Medical Education	0	2,798,131	0.000000	403,594	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet D-1 Date/Time Prepared: 8/21/2020 10:06 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,195 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,807 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,352 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,005 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)			336 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			35 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)			12 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			50 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			120.63 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			131.13 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,798,131 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)			4,222 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)			1,574 25.00
26.00	Total swing-bed cost (see instructions)			1,195,290 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,602,841 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,602,841 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)			887.02 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			44,351 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)			44,351 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1328

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

Worksheet D-1

Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		Title XIX		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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					44,351	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					455	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					887.02	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					403,594	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1328

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

Worksheet D-1

Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	74,461	2,798,131	0.026611	403,594	10,740	90.00
91.00	Nursing School cost	0	2,798,131	0.000000	403,594	0	91.00
92.00	Allied health cost	0	2,798,131	0.000000	403,594	0	92.00
93.00	All other Medical Education	0	2,798,131	0.000000	403,594	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/21/2020 10:06 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		856,478		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195369	248,159	48,483	54.00
60.00	06000 LABORATORY	0.361517	328,471	118,748	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.367625	46,653	17,151	65.00
66.00	06600 PHYSICAL THERAPY	0.307568	42,163	12,968	66.00
69.00	06900 ELECTROCARDIOLOGY	0.230529	13,097	3,019	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.280316	180,457	50,585	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.344588	360,010	124,055	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.792861	0	0	90.00
91.00	09100 EMERGENCY	0.709038	17,806	12,625	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.305082	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,236,816	387,634	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)		1,236,816		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1328 Component CCN: 14-Z328	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/21/2020 10:06 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195369	57,094	11,154	54.00
60.00	06000 LABORATORY	0.361517	114,205	41,287	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.367625	37,280	13,705	65.00
66.00	06600 PHYSICAL THERAPY	0.307568	267,481	82,269	66.00
69.00	06900 ELECTROCARDIOLOGY	0.230529	2,649	611	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.280316	137,540	38,555	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.344588	253,352	87,302	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.792861	0	0	90.00
91.00	09100 EMERGENCY	0.709038	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.305082	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		869,601	274,883	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)		869,601		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part B Date/Time Prepared: 8/21/2020 10:06 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,106,361	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)		2,106,361	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,127,425	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)		17,758	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		754,103	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,355,564	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,355,564	30.00
31.00	Primary payer payments		123	31.00
32.00	Subtotal (line 30 minus line 31)		1,355,441	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)		272,081	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		176,853	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		272,081	36.00
37.00	Subtotal (see instructions)		1,532,294	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)		1,532,294	40.00
40.01	Sequestration adjustment (see instructions)		30,646	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		1,440,381	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)		61,267	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part B Date/Time Prepared: 8/21/2020 10:06 am
		Title XVIII	Hospital	Cost
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet E-1
Part I
Date/Time Prepared:
8/21/2020 10:06 am

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,103,106		1,335,579	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0	03/25/2020	104,802	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		10/23/2019	36,232		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)		-36,232		104,802	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,066,874		1,440,381	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		61,267	6.01
6.02	SETTLEMENT TO PROGRAM		81,948		0	6.02
7.00	Total Medicare program liability (see instructions)		984,926		1,501,648	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: 14-1328

Period:

Worksheet E-1

Component CCN: 14-Z328

From 04/01/2019
To 03/31/2020Part I
Date/Time Prepared:
8/21/2020 10:06 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		1,444,396		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,444,396		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		185,285		0	6.02
7.00	Total Medicare program liability (see instructions)		1,259,111		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: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet E-1
Part II
Date/Time Prepared:
8/21/2020 10:06 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
				Overrides
				1.00
	CONTRACTOR OVERRIDES			
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1328

Period:

Worksheet E-2

Component CCN: 14-Z328

From 04/01/2019

To 03/31/2020

Date/Time Prepared:
8/21/2020 10:06 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)		1,064,318	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)		277,632	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,188	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,341,950	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,341,950	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,341,950	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		80,922	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,261,028	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)		36,583	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		23,779	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,583	0	18.00
19.00	Total (see instructions)		1,284,807	0	19.00
19.01	Sequestration adjustment (see instructions)		25,696	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		1,444,396	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)		-185,285	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: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet E-3 Part V Date/Time Prepared: 8/21/2020 10:06 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,185,065	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,185,065	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,196,916	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,196,916	19.00
20.00	Deductibles (exclude professional component)		228,448	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		968,468	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		968,468	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		56,245	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		36,559	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		56,245	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,005,027	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,005,027	30.00
30.01	Sequestration adjustment (see instructions)		20,101	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,066,874	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)		-81,948	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1328	Period: From 04/01/2019 To 03/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/21/2020 10:06 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		44,351		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		44,351	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		44,351	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		44,351	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		44,351	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		44,351	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		44,351	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		44,351	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		44,351	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		44,351	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		44,351	0	40.00
41.00	Interim payments		249,234	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-204,883	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

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

Provider CCN: 14-1328

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

Worksheet G

Date/Time Prepared:
8/21/2020 10:06 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	533,151	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	2,531,734	0	0	0	4.00
5.00	Other receivable	104,987	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,388,914	0	0	0	6.00
7.00	Inventory	216,021	0	0	0	7.00
8.00	Prepaid expenses	10,502	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)	2,007,481	0	0	0	11.00
FIXED ASSETS						
12.00	Land	17,000	0	0	0	12.00
13.00	Land improvements	256,674	0	0	0	13.00
14.00	Accumulated depreciation	-182,809	0	0	0	14.00
15.00	Buildings	1,796,754	0	0	0	15.00
16.00	Accumulated depreciation	-1,475,423	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,100,488	0	0	0	23.00
24.00	Accumulated depreciation	-3,507,055	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,005,629	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	3,013,110	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	368,305	0	0	0	37.00
38.00	Salaries, wages, and fees payable	696,599	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	54,445	0	0	0	40.00
41.00	Deferred income	13,112	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	185,653	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,318,114	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	220,899	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)	220,899	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,539,013	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,474,097	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)	1,474,097	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	3,013,110	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1328

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

Worksheet G-1

Date/Time Prepared:
8/21/2020 10:06 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		1,073,475		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		400,622				2.00
3.00	Total (sum of line 1 and line 2)		1,474,097		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	PRIOR YEAR ADJUSTMENTS	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,474,097		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,474,097		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	PRIOR YEAR ADJUSTMENTS		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: 14-1328

Period:
From 04/01/2019
To 03/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/21/2020 10:06 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,781,000		1,781,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	1,003,981		1,003,981	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,784,981		2,784,981	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)	2,784,981		2,784,981	17.00
18.00	Ancillary services	3,972,066	11,077,235	15,049,301	18.00
19.00	Outpatient services	485,778	1,222,500	1,708,278	19.00
20.00	RURAL HEALTH CLINIC	0	1,283,876	1,283,876	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,242,825	13,583,611	20,826,436	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		11,117,627		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		11,117,627		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1328

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

Worksheet G-3

Date/Time Prepared:
8/21/2020 10:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	20,826,436	1.00
2.00	Less contractual allowances and discounts on patients' accounts	10,217,970	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,608,466	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	11,117,627	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-509,161	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	8,141	6.00
7.00	Income from investments	11,596	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	95,995	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	3,041	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	2,262	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	2,255	24.00
24.01	GRANTS	186,869	24.01
24.02	DEFERRED REVENUE	3,919	24.02
24.03	SITE FEES	0	24.03
24.04	EHR INCENTIVE	0	24.04
24.05	340B PROGRAM	595,705	24.05
25.00	Total other income (sum of lines 6-24)	909,783	25.00
26.00	Total (line 5 plus line 25)	400,622	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	400,622	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1328

Period:

Worksheet M-1

Component CCN: 14-3479

From 04/01/2019

Date/Time Prepared:

To 03/31/2020

8/21/2020 10:06 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	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	499,784	23,715	523,499	0	523,499 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	193,505	27,985	221,490	0	221,490 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	210,657	38,669	249,326	0	249,326 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	357,264	91,166	448,430	0	448,430 9.00
10.00	Subtotal (sum of lines 1 through 9)	1,261,210	181,535	1,442,745	0	1,442,745 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	988	988	0	988 15.00
16.00	Transportation (Health Care Staff)	0	362	362	0	362 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	52,714	52,714	0	52,714 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	54,064	54,064	0	54,064 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,261,210	235,599	1,496,809	0	1,496,809 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	49,456	49,456	0	49,456 29.00
30.00	Administrative Costs	0	0	0	7,987	7,987 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	49,456	49,456	7,987	57,443 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,261,210	285,055	1,546,265	7,987	1,554,252 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1328

Period:

Worksheet M-1

Component CCN: 14-3479

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/21/2020 10:06 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	523,499	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	221,490	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	249,326	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	448,430	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,442,745	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	988	15.00
16.00	Transportation (Health Care Staff)	0	362	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	52,714	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	54,064	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,496,809	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	49,456	29.00
30.00	Administrative Costs	0	7,987	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	57,443	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,554,252	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1328

Period:

Worksheet M-2

Component CCN: 14-3479

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/21/2020 10:06 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	1.48	6,580	4,200	6,216		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.32	3,920	2,100	2,772		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.80	10,500		8,988	10,500	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.80	10,500			10,500	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)					1,496,809	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,496,809	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					57,443	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					536,699	15.00
16.00	Total overhead (sum of lines 14 and 15)					594,142	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					594,142	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					594,142	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,090,951	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1328 Component CCN: 14-3479	Period: From 04/01/2019 To 03/31/2020	Worksheet M-3 Date/Time Prepared: 8/21/2020 10:06 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)			2,090,951	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			16,192	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,074,759	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,500	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)			10,500	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			197.60	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)			197.60	197.60	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	3,993	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	789,017	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	789,017	16.00
16.01	Total program charges (see instructions)(from contractor's records)				508,817	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				1,766	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				2,739	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.)				577,505	16.04
16.05	Total program cost (see instructions)			0	580,244	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				64,397	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				88,884	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				580,244	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				10,140	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				590,384	22.00
23.00	Allowable bad debts (see instructions)				47,167	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				30,659	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				47,167	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)				621,043	26.00
26.01	Sequestration adjustment (see instructions)				12,421	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				543,313	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)				65,309	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: 14-1328 Component CCN: 14-3479	Period: From 04/01/2019 To 03/31/2020	Worksheet M-4 Date/Time Prepared: 8/21/2020 10:06 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,442,745	1,442,745	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000194	0.002120	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		280	3,059	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,305	6,947	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,585	10,006	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,496,809	1,496,809	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		594,142	594,142	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001059	0.006685	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		629	3,972	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,214	13,978	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		43	470	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		51.49	29.74	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		30	289	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,545	8,595	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)			16,192	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)			10,140	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1328 Component CCN: 14-3479	Period: From 04/01/2019 To 03/31/2020	Worksheet M-5 Date/Time Prepared: 8/21/2020 10:06 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		534,600	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01		10/23/2019	8,713	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)		8,713	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		543,313	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		65,309	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		608,622	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00