

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet S Parts I-III Date/Time Prepared: 8/24/2020 11:39 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/24/2020	Time: 11:39 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SARAH D CULBERTSON (14-1333) for the cost reporting period beginning 03/01/2019 and ending 02/29/2020 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) JOHN KESSLER

Officer or Administrator of Provider(s)

CEO

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	139,946	-382,266	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	112,283	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-111,289		0	10.00
200.00	Total	0	252,229	-493,555	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:39 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 238 SOUTH CONGRESS			PO Box:				1.00				
2.00	City: RUSHVILLE			State: IL		Zip Code: 62681		County: SCHUYLER				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			SARAH D CULBERTSON	141333	99914	1	05/01/2004	N	O	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			SDCMH SWING BED- SNF	14Z333	99914		05/01/2004	N	O	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC			ELMER HUGH TAYLOR CLINIC	143483	99914		10/01/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						03/01/2019		02/29/2020		20.00	
21.00	Type of Control (see instructions)						11				21.00	
							1.00		2.00		3.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N						22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		N				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N				23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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	0	24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:39 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.					N			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: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet S-2
Part I
Date/Time Prepared:
8/24/2020 11:39 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		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet S-2
Part I
Date/Time Prepared:
8/24/2020 11:39 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:39 am	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
						1.00	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
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				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	84,052		0	0	118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N				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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:39 am	
		1.00		2.00			
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	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet S-2 Part I Date/Time Prepared: 8/24/2020 11:39 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet S-2 Part II Date/Time Prepared: 8/24/2020 11:39 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.	Y					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	Date		
		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)	N		N			16.00
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)	Y	04/22/2020	Y	04/22/2020		17.00
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			18.00
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			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet S-2
Part II
Date/Time Prepared:
8/24/2020 11:39 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		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.	DAVID	MCCLUNG		41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	641-494-2144	DAVID.MCCLUNG@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet S-2 Part II Date/Time Prepared: 8/24/2020 11:39 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.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet S-3
Part I
Date/Time Prepared:
8/24/2020 11:39 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	10,301.00	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)		22	8,030	10,301.00	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)		22	8,030	10,301.00	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 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				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: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet S-3
Part I
Date/Time Prepared:
8/24/2020 11:39 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)	315	36	423		1.00
2.00	HMO and other (see instructions)	18	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	409	0	440		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	23		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	724	36	886		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)	724	36	886	0.00	132.84
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RHC (CONSOLIDATED)	3,812	681	15,203	0.00	25.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	19.81
27.00	Total (sum of lines 14-26)				0.00	0.00
28.00	Observation Bed Days		0	297		26.25
29.00	Ambulance Trips	0				27.00
30.00	Employee discount days (see instruction)			0		152.65
31.00	Employee discount days - IRF			0		28.00
32.00	Labor & delivery days (see instructions)	0	0	0		29.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		30.00
33.00	LTCH non-covered days	0				31.00
33.01	LTCH site neutral days and discharges	0				32.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet S-3
Part I
Date/Time Prepared:
8/24/2020 11:39 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	102	5	265	1.00
2.00 HMO and other (see instructions)			3	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	102	5	265	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 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1333 Component CCN: 14-3483		Period: From 03/01/2019 To 02/29/2020		Worksheet S-8 Date/Time Prepared: 8/24/2020 11:39 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				238 S. CONGRESS		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				RUSHVILLE		IL 62681		2.00
								1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		17:00		08:00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y		4		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number				COMMUNITY MEDICAL CLINIC		143484		14.00
14.01					ELMER HUGH TAYLOR CLINIC		143483		14.01
14.02					RUSHVILLE FAMILY PRACTICE		148578		14.02
14.03					COMMUNITY MEDICAL CLINIC OF TABLE GR		148585		14.03
				Y/N		V		XVIII	
				1.00		2.00		3.00	
								XIX	
								Total Visits	
								5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				SCHUYLER				2.00

MCRIF32 - 16.2.168.1

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet S-10

Date/Time Prepared:
8/24/2020 11:39 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)		0.594263	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		2,635,080	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		2,291,711	5.00
6.00	Medicaid charges		9,166,842	6.00
7.00	Medicaid cost (line 1 times line 6)		5,447,515	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)		520,724	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)		520,724	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	32,498	33,414	65,912
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	19,312	33,414	52,726
22.00	Payments received from patients for amounts previously written off as charity care	2,991	7,927	10,918
23.00	Cost of charity care (line 21 minus line 22)	16,321	25,487	41,808
				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
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,194,596
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			212,167
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			326,410
28.00	Non-Medicare bad debt expense (see instructions)			868,186
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			630,174
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			671,982
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,192,706

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet A

Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		506,160	506,160	18,826	524,986	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME		111,508	111,508	3,435	114,943	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME		25,036	25,036	1,885	26,921	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		412,931	412,931	14,289	427,220	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,360,098	3,360,098	0	3,360,098	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	212,154	196,515	408,669	0	408,669	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	379,952	295,436	675,388	0	675,388	5.04
5.05	00590	OTHER ADMIN. & GENERAL	678,167	1,325,109	2,003,276	-43,493	1,959,783	5.05
6.00	00600	MAINTENANCE & REPAIRS	161,789	104,280	266,069	0	266,069	6.00
7.00	00700	OPERATION OF PLANT	62,007	179,831	241,838	0	241,838	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	23,470	23,470	77,435	100,905	7.01
9.00	00900	HOUSEKEEPING	233,600	23,235	256,835	0	256,835	9.00
10.00	01000	DIETARY	313,017	275,980	588,997	0	588,997	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	146,042	5,642	151,684	0	151,684	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	370,493	113,377	483,870	0	483,870	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	186,927	0	186,927	0	186,927	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	734,707	196,590	931,297	0	931,297	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	136,714	185,854	322,568	0	322,568	50.00
53.00	05300	ANESTHESIOLOGY	0	15,497	15,497	0	15,497	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460,852	561,604	1,022,456	47,916	1,070,372	54.00
60.00	06000	LABORATORY	479,577	660,506	1,140,083	34,151	1,174,234	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	40,641	40,641	0	40,641	62.00
65.00	06500	RESPIRATORY THERAPY	30,647	32,437	63,084	0	63,084	65.00
66.00	06600	PHYSICAL THERAPY	273,520	189,786	463,306	-148,410	314,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	124,878	0	124,878	78,637	203,515	67.00
68.00	06800	SPEECH PATHOLOGY	71,774	0	71,774	69,773	141,547	68.00
69.00	06900	ELECTROCARDIOLOGY	122,669	139,408	262,077	0	262,077	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	91,304	91,304	0	91,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	811,202	811,202	0	811,202	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,311,244	457,371	2,768,615	-159,502	2,609,113	88.00
90.00	09000	CLINIC	218,670	1,890,597	2,109,267	0	2,109,267	90.00
90.02	09002	GEROPSYCH	138,868	106,451	245,319	0	245,319	90.02
91.00	09100	EMERGENCY	522,209	2,122,572	2,644,781	0	2,644,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,370,477	14,460,428	22,830,905	-5,058	22,825,847	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	143,603	90,147	233,750	5,058	238,808	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	19,925	29,153	49,078	0	49,078	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	8,534,005	14,579,728	23,113,733	0	23,113,733	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet A

Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	524,986	1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	-1,500	113,443	1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	26,921	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-8,679	418,541	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-456,831	2,903,267	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	-12,558	396,111	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	-72,788	602,600	5.04
5.05	00590	OTHER ADMIN. & GENERAL	-279,370	1,680,413	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	266,069	6.00
7.00	00700	OPERATION OF PLANT	-537	241,301	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	100,905	7.01
9.00	00900	HOUSEKEEPING	0	256,835	9.00
10.00	01000	DIETARY	-155,940	433,057	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	151,684	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,076	477,794	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	186,927	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	931,297	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-127,766	194,802	50.00
53.00	05300	ANESTHESIOLOGY	0	15,497	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,070,372	54.00
60.00	06000	LABORATORY	0	1,174,234	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	40,641	62.00
65.00	06500	RESPIRATORY THERAPY	0	63,084	65.00
66.00	06600	PHYSICAL THERAPY	0	314,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	203,515	67.00
68.00	06800	SPEECH PATHOLOGY	0	141,547	68.00
69.00	06900	ELECTROCARDIOLOGY	-34,280	227,797	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	91,304	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	811,202	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-105,101	2,504,012	88.00
90.00	09000	CLINIC	-558,029	1,551,238	90.00
90.02	09002	GEROPSYCH	0	245,319	90.02
91.00	09100	EMERGENCY	-256,409	2,388,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,075,864	20,749,983	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	238,808	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	194.01
194.02	07952	FOUNDATION	0	49,078	194.02
194.03	07953	OUTPATIENT MEALS	0	0	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,075,864	21,037,869	200.00

RECLASSIFICATIONS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-6

Date/Time Prepared:
8/24/2020 11:39 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	38,435		1.00
2.00	CULBERTSON GARDENS	194.00	0	5,058		2.00
	TOTALS		0	43,493		
	C - RHC EXPENSES					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	47,916	0		1.00
2.00	LABORATORY	60.00	34,151	0		2.00
3.00	PLANT & HOUSEKEEPING-RHC	7.01	60,044	17,391		3.00
	TOTALS		142,111	17,391		
	D - THERAPY RECLASS					
1.00	OCCUPATIONAL THERAPY	67.00	41,045	37,592		1.00
2.00	SPEECH PATHOLOGY	68.00	36,418	33,355		2.00
	TOTALS		77,463	70,947		
500.00	Grand Total: Increases		219,574	131,831		500.00

RECLASSIFICATIONS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-6

Date/Time Prepared:
8/24/2020 11:39 am

Decreases						
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - PROPERTY INSURANCE						
1.00	OTHER ADMIN. & GENERAL	5.05	0	43,493	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	43,493		
C - RHC EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	142,111	17,391	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		142,111	17,391		
D - THERAPY RECLASS						
1.00	PHYSICAL THERAPY	66.00	77,463	70,947	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		77,463	70,947		
500.00	Grand Total: Decreases		219,574	131,831		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet A-7
Part I
Date/Time Prepared:
8/24/2020 11:39 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	426,152	0	0	0	36,288	1.00
2.00	Land Improvements	1,165,295	0	0	0	113,017	2.00
3.00	Buildings and Fixtures	6,805,777	0	0	0	1,404,809	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5,823,285	0	0	0	486,177	5.00
6.00	Movable Equipment	6,656,390	30,321	0	30,321	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,876,899	30,321	0	30,321	2,040,291	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,876,899	30,321	0	30,321	2,040,291	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	389,864	0				1.00
2.00	Land Improvements	1,052,278	0				2.00
3.00	Buildings and Fixtures	5,400,968	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	5,337,108	0				5.00
6.00	Movable Equipment	6,686,711	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	18,866,929	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	18,866,929	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet A-7
Part II
Date/Time Prepared:
8/24/2020 11:39 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	506,160	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	111,508	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	25,036	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	412,931	0	0	0	2.00
3.00	Total (sum of lines 1-2)	642,704	412,931	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1)				
		Capital-Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		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	506,160				1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	111,508				1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	25,036				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	412,931				2.00
3.00	Total (sum of lines 1-2)	0	1,055,635				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet A-7
Part III
Date/Time Prepared:
8/24/2020 11:39 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	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	8,649,850	0	8,649,850	0.489809	18,826	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	1,578,318	0	1,578,318	0.089374	3,435	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	866,056	0	866,056	0.049042	1,885	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	6,565,408	0	6,565,408	0.371775	14,289	2.00
3.00	Total (sum of lines 1-2)	17,659,632	0	17,659,632	1.000000	38,435	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	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	18,826	506,160	0	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	0	3,435	110,008	0	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	1,885	25,036	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	14,289	-8,679	412,931	2.00
3.00	Total (sum of lines 1-2)	0	0	38,435	632,525	412,931	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)	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	18,826	0	0	524,986	1.00
1.01	NEW CAP REL COSTS-RHCS BLDG/MME	0	3,435	0	0	113,443	1.01
1.02	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	1,885	0	0	26,921	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,289	0	0	418,541	2.00
3.00	Total (sum of lines 1-2)	0	38,435	0	0	1,083,891	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-8

Date/Time Prepared:
8/24/2020 11:39 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
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-RHCS BLDG/MME (chapter 2)			0	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-MED ARTS BLDG/MME (chapter 2)			0	NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-24,069		HOSPITAL ONLY ADMIN & GENERAL	5.04	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-538		OTHER ADMIN. & GENERAL	5.05	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-575		OTHER ADMIN. & GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-537		OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0			0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,064,036				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	-155,909		DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0			0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00	Sale of drugs to other than patients		0			0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,076		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00	Vending machines	B	-31		DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0		CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-RHCS BLDG/MME		0		NEW CAP REL COSTS-RHCS BLDG/MME	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-MED ARTS BLDG/MME		0		NEW CAP REL COSTS-MED ARTS BLDG/MME	1.02	0	26.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-8

Date/Time Prepared:
8/24/2020 11:39 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 #		
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A-8-3		0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0NONPHYSICIAN 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)		0OCCUPATIONAL THERAPY	67.00		30.00	
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-8,175	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	INTEREST INCOME	B	-385	OTHER ADMIN. & GENERAL	5.05	0	33.00
33.01	MISCELLANEOUS INCOME	B	-208,784	OTHER ADMIN. & GENERAL	5.05	0	33.01
33.03	MARKETING SALARY EXPENSE	A	-18,593	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.03
33.04	MARKETING BENEFITS EXPENSE	A	-6,349	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING OTHER EXPENSE	A	-53,133	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.05
33.06	MARKETING OTHER EXPENSE	A	-2,710	OTHER ADMIN. & GENERAL	5.05	0	33.06
33.07	MARKETING OTHER EXPENSE	A	-4,789	RURAL HEALTH CLINIC	88.00	0	33.07
33.08	MARKETING OTHER EXPENSE	A	-504	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	LOBBYING PORTION OF DUES	A	-762	OTHER ADMIN. & GENERAL	5.05	0	33.09
33.10	HEALTHLINK ADMINISTRATIVE FEES	A	23,007	HOSPITAL ONLY ADMIN & GENERAL	5.04	0	33.10
33.11	PART B PHYSICIAN BILLING SALARIES	A	-12,558	HOSPITAL BUSINESS OFFICE	5.02	0	33.11
33.12	PART B PHYSICIAN BILLING EMP BENEFIT	A	-4,288	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.14	PATIENT COLLECTION FEES	B	-65,161	OTHER ADMIN. & GENERAL	5.05	0	33.14
33.16	PROPERTY TAXES	A	-455	OTHER ADMIN. & GENERAL	5.05	0	33.16
33.17	IMRF CONTRIBUTION	A	-446,194	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	OPC RENT - CLINIC	B	-12,760	CLINIC	90.00	0	33.18
33.19	OPC RENT - RHC	B	-1,500	NEW CAP REL COSTS-RHCS BLDG/MME	1.01	9	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,075,864				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: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-8-2

Date/Time Prepared:
8/24/2020 11:39 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	50.00	OPERATING ROOM	127,766	127,766	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	12,000	0	12,000	0	0	2.00
3.00	60.00	LABORATORY	14,300	0	14,300	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	6,000	0	6,000	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	34,280	34,280	0	0	0	5.00
6.00	90.00	CLINIC	211,000	211,000	0	0	0	6.00
7.00	90.00	CLINIC	251,000	251,000	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.00	CLINIC	41,869	41,869	0	0	0	9.00
10.00	91.00	EMERGENCY	1,959,891	256,409	1,703,482	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	90,422	90,422	0	0	0	11.00
12.00	90.00	CLINIC	38,400	38,400	0	0	0	12.00
13.00	90.00	CLINIC	3,000	3,000	0	0	0	13.00
14.00	88.00	RURAL HEALTH CLINIC	9,290	9,290	0	0	0	14.00
15.00	88.00	RURAL HEALTH CLINIC	300	300	0	0	0	15.00
16.00	88.00	RURAL HEALTH CLINIC	300	300	0	0	0	16.00
200.00			2,799,818	1,064,036	1,735,782	0	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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
14.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	14.00
15.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	15.00
16.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	16.00
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	50.00	OPERATING ROOM	0	0	0	127,766	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	34,280	5.00
6.00	90.00	CLINIC	0	0	0	211,000	6.00
7.00	90.00	CLINIC	0	0	0	251,000	7.00
8.00	90.00	CLINIC	0	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	41,869	9.00
10.00	91.00	EMERGENCY	0	0	0	256,409	10.00
11.00	88.00	RURAL HEALTH CLINIC	0	0	0	90,422	11.00
12.00	90.00	CLINIC	0	0	0	38,400	12.00
13.00	90.00	CLINIC	0	0	0	3,000	13.00
14.00	88.00	RURAL HEALTH CLINIC	0	0	0	9,290	14.00
15.00	88.00	RURAL HEALTH CLINIC	0	0	0	300	15.00
16.00	88.00	RURAL HEALTH CLINIC	0	0	0	300	16.00
200.00			0	0	0	1,064,036	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/24/2020 11:39 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					50	1.00
2.00	Line 1 multiplied by 15 hours per week					750	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					353	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,015.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	109.25	87.40	65.55	30.59	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)	43.70	43.70	32.78			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)					176,111	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)					176,111	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)					176,111	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					176,111	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)					15,426	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)					15,426	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)					15,426	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)					15,426	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: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/24/2020 11:39 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	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	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)	87.40	65.55	30.59	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)					176,111	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					15,426	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)					191,537	63.00
64.00	Total cost of outside supplier services (from your records)					121,626	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					15,426	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					15,426	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: 14-1333

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Cost Center Description			CAPITAL RELATED COSTS					
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME	MVBLE EQUIP	
0			1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	524,986	524,986				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	113,443	0	113,443			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	26,921	0	0	26,921		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	418,541				418,541	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,903,267	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	396,111	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	602,600	31,359	0	0	25,001	5.04
5.05	00590	OTHER ADMIN. & GENERAL	1,680,413	45,644	0	0	36,389	5.05
6.00	00600	MAINTENANCE & REPAIRS	266,069	52,697	0	0	42,012	6.00
7.00	00700	OPERATION OF PLANT	241,301	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	100,905	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	256,835	19,103	0	0	15,229	9.00
10.00	01000	DIETARY	433,057	25,977	0	0	20,710	10.00
11.00	01100	CAFETERIA	0	8,875	0	0	7,076	11.00
13.00	01300	NURSING ADMINISTRATION	151,684	1,127	0	0	898	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	477,794	22,756	0	0	18,142	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	186,927	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	931,297	56,209	0	0	44,812	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	194,802	39,717	0	0	31,664	50.00
53.00	05300	ANESTHESIOLOGY	15,497	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,070,372	29,621	0	0	23,615	54.00
60.00	06000	LABORATORY	1,174,234	11,214	0	0	8,940	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	40,641	939	0	0	749	62.00
65.00	06500	RESPIRATORY THERAPY	63,084	7,100	0	0	5,661	65.00
66.00	06600	PHYSICAL THERAPY	314,896	17,074	0	0	13,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	203,515	8,659	0	0	6,903	67.00
68.00	06800	SPEECH PATHOLOGY	141,547	4,386	0	0	3,497	68.00
69.00	06900	ELECTROCARDIOLOGY	227,797	1,014	0	0	809	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,304	14,567	0	0	11,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	811,202	6,490	0	0	5,174	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,504,012	0	113,443	26,921	0	88.00
90.00	09000	CLINIC	1,551,238	73,152	0	0	58,321	90.00
90.02	09002	GEROPSYCH	245,319	25,649	0	0	20,448	90.02
91.00	09100	EMERGENCY	2,388,372	21,657	0	0	17,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,749,983	524,986	113,443	26,921	418,541	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	238,808	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	49,078	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	21,037,869	524,986	113,443	26,921	418,541	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1333

Period:
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	Subtotal	HOSPITAL ONLY ADMIN & GENERAL	Subtotal	
			4.00	5.02	5A.02	5.04	5A.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,903,267					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	68,141	464,252				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	123,366	0	782,326	782,326		5.04
5.05	00590	OTHER ADMIN. & GENERAL	231,522	0	1,993,968	78,343	2,072,311	5.05
6.00	00600	MAINTENANCE & REPAIRS	55,234	0	416,012	16,345	432,357	6.00
7.00	00700	OPERATION OF PLANT	21,169	0	262,470	10,312	272,782	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	20,499	0	121,404	4,770	126,174	7.01
9.00	00900	HOUSEKEEPING	79,750	0	370,917	14,573	385,490	9.00
10.00	01000	DIETARY	106,862	0	586,606	23,048	609,654	10.00
11.00	01100	CAFETERIA	0	0	15,951	627	16,578	11.00
13.00	01300	NURSING ADMINISTRATION	49,858	0	203,567	7,998	211,565	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	126,484	0	645,176	25,349	670,525	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	63,816	0	250,743	9,852	260,595	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	250,825	19,564	1,302,707	51,183	1,353,890	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,673	12,633	325,489	12,788	338,277	50.00
53.00	05300	ANESTHESIOLOGY	0	5,184	20,681	813	21,494	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	173,690	124,340	1,421,638	55,856	1,477,494	54.00
60.00	06000	LABORATORY	175,384	91,932	1,461,704	57,430	1,519,134	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,355	43,684	1,716	45,400	62.00
65.00	06500	RESPIRATORY THERAPY	10,463	2,193	88,501	3,477	91,978	65.00
66.00	06600	PHYSICAL THERAPY	66,933	18,084	430,599	16,918	447,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,645	6,441	282,163	11,086	293,249	67.00
68.00	06800	SPEECH PATHOLOGY	36,936	5,716	192,082	7,547	199,629	68.00
69.00	06900	ELECTROCARDIOLOGY	41,878	27,633	299,131	11,753	310,884	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,504	120,988	4,754	125,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,436	844,302	33,173	877,475	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	740,524	35,483	3,420,383	134,395	3,554,778	88.00
90.00	09000	CLINIC	74,653	53,629	1,810,993	71,154	1,882,147	90.00
90.02	09002	GEROPSYCH	47,409	1,099	339,924	13,356	353,280	90.02
91.00	09100	EMERGENCY	178,279	34,026	2,639,600	103,710	2,743,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,846,993	464,252	20,693,709	782,326	20,693,709	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	49,472	0	288,280	0	288,280	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	6,802	0	55,880	0	55,880	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	2,903,267	464,252	21,037,869	782,326	21,037,869	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			OTHER ADMIN. & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING- RHC	HOUSEKEEPING	
			5.05	6.00	7.00	7.01	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL	2,072,311					5.05
6.00	00600	MAINTENANCE & REPAIRS	47,242	479,599				6.00
7.00	00700	OPERATION OF PLANT	29,806	0	302,588			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	13,787	0	0	139,961		7.01
9.00	00900	HOUSEKEEPING	42,121	23,177	14,623	0	465,411	9.00
10.00	01000	DIETARY	66,615	31,518	19,885	0	32,139	10.00
11.00	01100	CAFETERIA	1,811	10,768	6,794	0	10,980	11.00
13.00	01300	NURSING ADMINISTRATION	23,117	1,367	863	0	1,394	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	73,266	27,610	17,420	0	28,154	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	28,474	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	147,935	68,198	43,028	0	69,541	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,963	48,189	30,403	0	49,138	50.00
53.00	05300	ANESTHESIOLOGY	2,349	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	161,441	35,939	22,675	0	36,647	54.00
60.00	06000	LABORATORY	165,991	13,605	8,584	0	13,873	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,961	1,139	719	0	1,162	62.00
65.00	06500	RESPIRATORY THERAPY	10,050	8,615	5,435	0	8,784	65.00
66.00	06600	PHYSICAL THERAPY	48,899	20,716	13,070	0	21,124	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,042	10,506	6,628	0	10,713	67.00
68.00	06800	SPEECH PATHOLOGY	21,813	5,321	3,357	0	5,426	68.00
69.00	06900	ELECTROCARDIOLOGY	33,969	1,231	776	0	1,255	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,739	17,673	11,151	0	18,022	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,879	7,874	4,968	0	8,029	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	388,424	0	0	139,961	0	88.00
90.00	09000	CLINIC	205,657	88,757	55,997	0	90,504	90.00
90.02	09002	GEROPSYCH	38,602	31,119	19,634	0	31,732	90.02
91.00	09100	EMERGENCY	299,753	26,277	16,578	0	26,794	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,034,706	479,599	302,588	139,961	465,411	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	31,499	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	6,106	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	2,072,311	479,599	302,588	139,961	465,411	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			10.00	11.00	13.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	759,811					10.00
11.00	01100	CAFETERIA	417,760	464,691				11.00
13.00	01300	NURSING ADMINISTRATION	0	13,663	251,969			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	58,313	0	875,288		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	289,069	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	81,800	96,584	106,161	88,455	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	14,175	15,589	15,838	0	50.00
53.00	05300	ANESTHESIOLOGY	0	7,087	0	0	289,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,068	0	42,136	0	54.00
60.00	06000	LABORATORY	0	58,037	0	28,688	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,268	3,603	4,483	0	65.00
66.00	06600	PHYSICAL THERAPY	0	31,893	0	13,149	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,765	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,670	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,757	14,042	15,539	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	268,354	0	88.00
90.00	09000	CLINIC	0	25,632	28,182	170,635	0	90.00
90.02	09002	GEROPSYCH	0	15,789	17,343	0	0	90.02
91.00	09100	EMERGENCY	0	60,990	67,049	228,011	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	499,560	464,691	251,969	875,288	289,069	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	231,219	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	29,032	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	759,811	464,691	251,969	875,288	289,069	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1333

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME				1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.02	00592	HOSPITAL BUSINESS OFFICE				5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL				5.04
5.05	00590	OTHER ADMIN. & GENERAL				5.05
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC				7.01
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,055,592	0	2,055,592	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	548,572	0	548,572	50.00
53.00	05300	ANESTHESIOLOGY	319,999	0	319,999	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,827,400	0	1,827,400	54.00
60.00	06000	LABORATORY	1,807,912	0	1,807,912	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	53,381	0	53,381	62.00
65.00	06500	RESPIRATORY THERAPY	136,216	0	136,216	65.00
66.00	06600	PHYSICAL THERAPY	596,368	0	596,368	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,903	0	362,903	67.00
68.00	06800	SPEECH PATHOLOGY	241,216	0	241,216	68.00
69.00	06900	ELECTROCARDIOLOGY	390,453	0	390,453	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,327	0	186,327	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	994,225	0	994,225	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,351,517	0	4,351,517	88.00
90.00	09000	CLINIC	2,547,511	0	2,547,511	90.00
90.02	09002	GEROPSYCH	507,499	0	507,499	90.02
91.00	09100	EMERGENCY	3,468,762	0	3,468,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,395,853	0	20,395,853	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	550,998	0	550,998	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	194.01
194.02	07952	FOUNDATION	61,986	0	61,986	194.02
194.03	07953	OUTPATIENT MEALS	29,032	0	29,032	194.03
194.04	07954	VACANT SPACE	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,037,869	0	21,037,869	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1333

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Cost Center Description			CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	BLDG & FIXT	NEW RHCS BLDG/MME	NEW MED ARTS BLDG/MME		MVBLE EQUIP
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	0	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	31,359	0	0	25,001	5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	45,644	0	0	36,389	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	52,697	0	0	42,012	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	0	7.01
9.00	00900	HOUSEKEEPING	0	19,103	0	0	15,229	9.00
10.00	01000	DIETARY	0	25,977	0	0	20,710	10.00
11.00	01100	CAFETERIA	0	8,875	0	0	7,076	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,127	0	0	898	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,756	0	0	18,142	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	56,209	0	0	44,812	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	39,717	0	0	31,664	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,621	0	0	23,615	54.00
60.00	06000	LABORATORY	0	11,214	0	0	8,940	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	939	0	0	749	62.00
65.00	06500	RESPIRATORY THERAPY	0	7,100	0	0	5,661	65.00
66.00	06600	PHYSICAL THERAPY	0	17,074	0	0	13,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,659	0	0	6,903	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,386	0	0	3,497	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,014	0	0	809	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,567	0	0	11,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,490	0	0	5,174	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	113,443	26,921	0	88.00
90.00	09000	CLINIC	0	73,152	0	0	58,321	90.00
90.02	09002	GEROPSYCH	0	25,649	0	0	20,448	90.02
91.00	09100	EMERGENCY	0	21,657	0	0	17,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0	524,986	113,443	26,921	418,541	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	524,986	113,443	26,921	418,541	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	HOSPITAL BUSINESS OFFICE	HOSPITAL ONLY ADMIN & GENERAL	OTHER ADMIN. & GENERAL	
			2A	4.00	5.02	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	56,360	0	0	56,360		5.04
5.05	00590	OTHER ADMIN. & GENERAL	82,033	0	0	5,645	87,678	5.05
6.00	00600	MAINTENANCE & REPAIRS	94,709	0	0	1,178	1,999	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	743	1,261	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	344	583	7.01
9.00	00900	HOUSEKEEPING	34,332	0	0	1,050	1,782	9.00
10.00	01000	DIETARY	46,687	0	0	1,661	2,818	10.00
11.00	01100	CAFETERIA	15,951	0	0	45	77	11.00
13.00	01300	NURSING ADMINISTRATION	2,025	0	0	576	978	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40,898	0	0	1,826	3,100	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	710	1,205	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	101,021	0	0	3,688	6,259	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	71,381	0	0	921	1,564	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	59	99	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,236	0	0	4,025	6,830	54.00
60.00	06000	LABORATORY	20,154	0	0	4,138	7,023	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,688	0	0	124	210	62.00
65.00	06500	RESPIRATORY THERAPY	12,761	0	0	251	425	65.00
66.00	06600	PHYSICAL THERAPY	30,686	0	0	1,219	2,069	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,562	0	0	799	1,356	67.00
68.00	06800	SPEECH PATHOLOGY	7,883	0	0	544	923	68.00
69.00	06900	ELECTROCARDIOLOGY	1,823	0	0	847	1,437	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,180	0	0	343	581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,664	0	0	2,390	4,057	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	140,364	0	0	9,672	16,435	88.00
90.00	09000	CLINIC	131,473	0	0	5,127	8,701	90.00
90.02	09002	GEROPSYCH	46,097	0	0	962	1,633	90.02
91.00	09100	EMERGENCY	38,923	0	0	7,473	12,682	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,083,891	0	0	56,360	86,087	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	1,333	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	258	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,083,891	0	0	56,360	87,678	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	PLANT & HOUSEKEEPING- RHC	HOUSEKEEPING	DIETARY	
			6.00	7.00	7.01	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	97,886					6.00
7.00	00700	OPERATION OF PLANT	0	2,004				7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	927			7.01
9.00	00900	HOUSEKEEPING	4,730	97	0	41,991		9.00
10.00	01000	DIETARY	6,433	132	0	2,900	60,631	10.00
11.00	01100	CAFETERIA	2,198	45	0	991	33,336	11.00
13.00	01300	NURSING ADMINISTRATION	279	6	0	126	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,635	115	0	2,540	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,919	285	0	6,274	6,527	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,835	201	0	4,433	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,335	150	0	3,306	0	54.00
60.00	06000	LABORATORY	2,777	57	0	1,252	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	233	5	0	105	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,758	36	0	793	0	65.00
66.00	06600	PHYSICAL THERAPY	4,228	87	0	1,906	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,144	44	0	967	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,086	22	0	490	0	68.00
69.00	06900	ELECTROCARDIOLOGY	251	5	0	113	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,607	74	0	1,626	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,607	33	0	724	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	927	0	0	88.00
90.00	09000	CLINIC	18,117	370	0	8,165	0	90.00
90.02	09002	GEROPSYCH	6,351	130	0	2,863	0	90.02
91.00	09100	EMERGENCY	5,363	110	0	2,417	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,886	2,004	927	41,991	39,863	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	18,451	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	2,317	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	97,886	2,004	927	41,991	60,631	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAFETERIA	NURSING ADMINISTRATIO N	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	
			11.00	13.00	16.00	19.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE						5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL						5.04
5.05	00590	OTHER ADMIN. & GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC						7.01
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	52,643					11.00
13.00	01300	NURSING ADMINISTRATION	1,548	5,538				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,606	0	60,720			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,915		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,942	2,333	6,136		157,384	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,606	343	1,099		91,383	50.00
53.00	05300	ANESTHESIOLOGY	803	0	0		961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,785	0	2,923		83,590	54.00
60.00	06000	LABORATORY	6,575	0	1,990		43,966	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		2,365	62.00
65.00	06500	RESPIRATORY THERAPY	370	79	311		16,784	65.00
66.00	06600	PHYSICAL THERAPY	3,613	0	912		44,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,106	0	0		21,978	67.00
68.00	06800	SPEECH PATHOLOGY	642	0	0		11,590	68.00
69.00	06900	ELECTROCARDIOLOGY	1,445	309	1,078		7,308	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		32,411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		20,475	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	18,617		186,015	88.00
90.00	09000	CLINIC	2,904	619	11,837		187,313	90.00
90.02	09002	GEROPSYCH	1,789	381	0		60,206	90.02
91.00	09100	EMERGENCY	6,909	1,474	15,817		91,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,643	5,538	60,720	0	1,059,617	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0		19,784	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0		0	194.01
194.02	07952	FOUNDATION	0	0	0		258	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0		2,317	194.03
194.04	07954	VACANT SPACE	0	0	0		0	194.04
200.00		Cross Foot Adjustments				1,915	1,915	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,643	5,538	60,720	1,915	1,083,891	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME			1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.02	00592	HOSPITAL BUSINESS OFFICE			5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL			5.04
5.05	00590	OTHER ADMIN. & GENERAL			5.05
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC			7.01
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	157,384	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	91,383	50.00
53.00	05300	ANESTHESIOLOGY	0	961	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	83,590	54.00
60.00	06000	LABORATORY	0	43,966	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,365	62.00
65.00	06500	RESPIRATORY THERAPY	0	16,784	65.00
66.00	06600	PHYSICAL THERAPY	0	44,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,978	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,590	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,308	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,411	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,475	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	186,015	88.00
90.00	09000	CLINIC	0	187,313	90.00
90.02	09002	GEROPSYCH	0	60,206	90.02
91.00	09100	EMERGENCY	0	91,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,059,617	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	19,784	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	194.01
194.02	07952	FOUNDATION	0	258	194.02
194.03	07953	OUTPATIENT MEALS	0	2,317	194.03
194.04	07954	VACANT SPACE	0	0	194.04
200.00		Cross Foot Adjustments	0	1,915	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,083,891	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	
			BLDG & FIXT (SQUARE FEET)	NEW RHCS BLDG/MME (SQUARE FEET)	NEW MED ARTS BLDG/MME (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)		
			1.00	1.01	1.02	2.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,899					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME	0	13,300				1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME	0	0	9,400			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				55,899		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	8,504,166	4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	0	0	0	0	199,597	5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	3,339	0	0	3,339	361,359	5.04
5.05	00590	OTHER ADMIN. & GENERAL	4,860	0	0	4,860	678,167	5.05
6.00	00600	MAINTENANCE & REPAIRS	5,611	0	0	5,611	161,789	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	62,007	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	0	0	60,045	7.01
9.00	00900	HOUSEKEEPING	2,034	0	0	2,034	233,600	9.00
10.00	01000	DIETARY	2,766	0	0	2,766	313,017	10.00
11.00	01100	CAFETERIA	945	0	0	945	0	11.00
13.00	01300	NURSING ADMINISTRATION	120	0	0	120	146,042	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	0	0	2,423	370,493	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	186,927	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,985	0	0	5,985	734,707	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,229	0	0	4,229	136,714	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,154	0	0	3,154	508,768	54.00
60.00	06000	LABORATORY	1,194	0	0	1,194	513,728	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	0	0	100	0	62.00
65.00	06500	RESPIRATORY THERAPY	756	0	0	756	30,647	65.00
66.00	06600	PHYSICAL THERAPY	1,818	0	0	1,818	196,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	922	0	0	922	165,923	67.00
68.00	06800	SPEECH PATHOLOGY	467	0	0	467	108,192	68.00
69.00	06900	ELECTROCARDIOLOGY	108	0	0	108	122,669	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	0	0	1,551	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691	0	0	691	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	13,300	9,400	0	2,169,133	88.00
90.00	09000	CLINIC	7,789	0	0	7,789	218,670	90.00
90.02	09002	GEROPSYCH	2,731	0	0	2,731	138,868	90.02
91.00	09100	EMERGENCY	2,306	0	0	2,306	522,209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,899	13,300	9,400	55,899	8,339,328	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	144,913	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	19,925	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	524,986	113,443	26,921	418,541	2,903,267	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.391689	8.529549	2.863936	7.487451	0.341394	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description			HOSPITAL BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	HOSPITAL ONLY ADMIN & GENERAL (ACCUM. COST)	Reconciliation	OTHER ADMIN. & GENERAL (ACCUM. COST)	
			5.02	5A.04	5.04	5A.05	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME						1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.02	00592	HOSPITAL BUSINESS OFFICE	34,321,252					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL	0	-782,326	19,911,383			5.04
5.05	00590	OTHER ADMIN. & GENERAL	0	0	1,993,968	-2,072,311	18,965,558	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	416,012	0	432,357	6.00
7.00	00700	OPERATION OF PLANT	0	0	262,470	0	272,782	7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	121,404	0	126,174	7.01
9.00	00900	HOUSEKEEPING	0	0	370,917	0	385,490	9.00
10.00	01000	DIETARY	0	0	586,606	0	609,654	10.00
11.00	01100	CAFETERIA	0	0	15,951	0	16,578	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	203,567	0	211,565	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	645,176	0	670,525	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	250,743	0	260,595	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,446,277	0	1,302,707	0	1,353,890	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	933,942	0	325,489	0	338,277	50.00
53.00	05300	ANESTHESIOLOGY	383,237	0	20,681	0	21,494	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,192,911	0	1,421,638	0	1,477,494	54.00
60.00	06000	LABORATORY	6,796,191	0	1,461,704	0	1,519,134	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100,139	0	43,684	0	45,400	62.00
65.00	06500	RESPIRATORY THERAPY	162,127	0	88,501	0	91,978	65.00
66.00	06600	PHYSICAL THERAPY	1,336,875	0	430,599	0	447,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	476,161	0	282,163	0	293,249	67.00
68.00	06800	SPEECH PATHOLOGY	422,531	0	192,082	0	199,629	68.00
69.00	06900	ELECTROCARDIOLOGY	2,042,781	0	299,131	0	310,884	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	259,003	0	120,988	0	125,742	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,584,650	0	844,302	0	877,475	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,623,158	0	3,420,383	0	3,554,778	88.00
90.00	09000	CLINIC	3,964,621	0	1,810,993	0	1,882,147	90.00
90.02	09002	GEROPSYCH	81,234	0	339,924	0	353,280	90.02
91.00	09100	EMERGENCY	2,515,414	0	2,639,600	0	2,743,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,321,252	-782,326	19,911,383	-2,072,311	18,621,398	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	-288,280	0	0	288,280	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	-55,880	0	0	55,880	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	0	194.04
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)	464,252		782,326		2,072,311	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.013527		0.039290		0.109267	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		56,360		87,678	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.002831		0.004623	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: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	PLANT & HOUSEKEEPING- RHC (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	7.01	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL					5.04
5.05	00590	OTHER ADMIN. & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS	42,089				6.00
7.00	00700	OPERATION OF PLANT	0	42,089			7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC	0	0	13,300		7.01
9.00	00900	HOUSEKEEPING	2,034	2,034	0	40,055	9.00
10.00	01000	DIETARY	2,766	2,766	0	2,766	37,294 10.00
11.00	01100	CAFETERIA	945	945	0	945	20,505 11.00
13.00	01300	NURSING ADMINISTRATION	120	120	0	120	0 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,423	2,423	0	2,423	0 16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,985	5,985	0	5,985	4,015 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,229	4,229	0	4,229	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,154	3,154	0	3,154	0 54.00
60.00	06000	LABORATORY	1,194	1,194	0	1,194	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	100	100	0	100	0 62.00
65.00	06500	RESPIRATORY THERAPY	756	756	0	756	0 65.00
66.00	06600	PHYSICAL THERAPY	1,818	1,818	0	1,818	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	922	922	0	922	0 67.00
68.00	06800	SPEECH PATHOLOGY	467	467	0	467	0 68.00
69.00	06900	ELECTROCARDIOLOGY	108	108	0	108	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,551	1,551	0	1,551	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	691	691	0	691	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	13,300	0	0 88.00
90.00	09000	CLINIC	7,789	7,789	0	7,789	0 90.00
90.02	09002	GEROPSYCH	2,731	2,731	0	2,731	0 90.02
91.00	09100	EMERGENCY	2,306	2,306	0	2,306	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,089	42,089	13,300	40,055	24,520 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	11,349 194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	0 194.01
194.02	07952	FOUNDATION	0	0	0	0	0 194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	1,425 194.03
194.04	07954	VACANT SPACE	0	0	0	0	0 194.04
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)	479,599	302,588	139,961	465,411	759,811 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.394878	7.189242	10.523383	11.619298	20.373545 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	97,886	2,004	927	41,991	60,631 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.325691	0.047613	0.069699	1.048334	1.625757 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: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet B-1

Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIO N (DIRECT NRS ING)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		11.00	13.00	16.00	19.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-RHCS BLDG/MME					1.01
1.02	00102	NEW CAP REL COSTS-MED ARTS BLDG/MME					1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.02	00592	HOSPITAL BUSINESS OFFICE					5.02
5.04	00591	HOSPITAL ONLY ADMIN & GENERAL					5.04
5.05	00590	OTHER ADMIN. & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	PLANT & HOUSEKEEPING-RHC					7.01
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	11,802				11.00
13.00	01300	NURSING ADMINISTRATION	347	69,372			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,481	0	2,929		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,453	29,228	296	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	360	4,292	53	0	50.00
53.00	05300	ANESTHESIOLOGY	180	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,297	0	141	0	54.00
60.00	06000	LABORATORY	1,474	0	96	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	83	992	15	0	65.00
66.00	06600	PHYSICAL THERAPY	810	0	44	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	248	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	144	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	324	3,866	52	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	898	0	88.00
90.00	09000	CLINIC	651	7,759	571	0	90.00
90.02	09002	GEROPSYCH	401	4,775	0	0	90.02
91.00	09100	EMERGENCY	1,549	18,460	763	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,802	69,372	2,929	100	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CULBERTSON GARDENS	0	0	0	0	194.00
194.01	07951	MEDICAL ARTS BUILDING	0	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	194.02
194.03	07953	OUTPATIENT MEALS	0	0	0	0	194.03
194.04	07954	VACANT SPACE	0	0	0	0	194.04
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)	464,691	251,969	875,288	289,069	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.373920	3.632143	298.835097	2,890.690000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,643	5,538	60,720	1,915	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.460515	0.079830	20.730625	19.150000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1333

Period:
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				Title XVIII	Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,055,592		2,055,592	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	548,572		548,572	0	0	50.00
53.00	05300	ANESTHESIOLOGY	319,999		319,999	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,827,400		1,827,400	0	0	54.00
60.00	06000	LABORATORY	1,807,912		1,807,912	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	53,381		53,381	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	136,216	0	136,216	0	0	65.00
66.00	06600	PHYSICAL THERAPY	596,368	0	596,368	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,903	0	362,903	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	241,216	0	241,216	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	390,453		390,453	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,327		186,327	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	994,225		994,225	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,351,517		4,351,517	0	0	88.00
90.00	09000	CLINIC	2,547,511		2,547,511	0	0	90.00
90.02	09002	GEROPSYCH	507,499		507,499	0	0	90.02
91.00	09100	EMERGENCY	3,468,762		3,468,762	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	525,378		525,378	0	0	92.00
200.00		Subtotal (see instructions)	20,921,231	0	20,921,231	0	0	200.00
201.00		Less Observation Beds	525,378		525,378	0	0	201.00
202.00		Total (see instructions)	20,395,853	0	20,395,853	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet C Part I Date/Time Prepared: 8/24/2020 11:39 am		
				Title XVIII			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
			Inpatient	Outpatient	Total (col. 6 + col. 7)					
			6.00	7.00	8.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	1,069,049		1,069,049				30.00	
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	2,736	931,206	933,942	0.587373	0.000000		50.00	
53.00	05300	ANESTHESIOLOGY	1,302	381,935	383,237	0.834990	0.000000		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,692	9,109,219	9,192,911	0.198784	0.000000		54.00	
60.00	06000	LABORATORY	302,336	6,493,855	6,796,191	0.266018	0.000000		60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,529	89,610	100,139	0.533069	0.000000		62.00	
65.00	06500	RESPIRATORY THERAPY	0	162,127	162,127	0.840181	0.000000		65.00	
66.00	06600	PHYSICAL THERAPY	107,027	1,229,848	1,336,875	0.446091	0.000000		66.00	
67.00	06700	OCCUPATIONAL THERAPY	89,790	386,371	476,161	0.762143	0.000000		67.00	
68.00	06800	SPEECH PATHOLOGY	10,275	412,256	422,531	0.570884	0.000000		68.00	
69.00	06900	ELECTROCARDIOLOGY	46,093	1,996,688	2,042,781	0.191138	0.000000		69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	158,842	100,161	259,003	0.719401	0.000000		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	364,407	1,220,243	1,584,650	0.627410	0.000000		73.00	
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	0	2,623,158	2,623,158				88.00	
90.00	09000	CLINIC	4,629	3,959,992	3,964,621	0.642561	0.000000		90.00	
90.02	09002	GEROPSYCH	0	81,234	81,234	6.247372	0.000000		90.02	
91.00	09100	EMERGENCY	15,141	2,500,273	2,515,414	1.379002	0.000000		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,357	373,871	377,228	1.392733	0.000000		92.00	
200.00		Subtotal (see instructions)	2,269,205	32,052,047	34,321,252				200.00	
201.00		Less Observation Beds							201.00	
202.00		Total (see instructions)	2,269,205	32,052,047	34,321,252				202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1333

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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					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
90.02	09002 GEROPSYCH	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-1333

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				Title XIX		Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,055,592		2,055,592	0	2,055,592	30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	548,572		548,572	0	548,572	50.00	
53.00	05300	ANESTHESIOLOGY	319,999		319,999	0	319,999	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,827,400		1,827,400	0	1,827,400	54.00	
60.00	06000	LABORATORY	1,807,912		1,807,912	0	1,807,912	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	53,381		53,381	0	53,381	62.00	
65.00	06500	RESPIRATORY THERAPY	136,216	0	136,216	0	136,216	65.00	
66.00	06600	PHYSICAL THERAPY	596,368	0	596,368	0	596,368	66.00	
67.00	06700	OCCUPATIONAL THERAPY	362,903	0	362,903	0	362,903	67.00	
68.00	06800	SPEECH PATHOLOGY	241,216	0	241,216	0	241,216	68.00	
69.00	06900	ELECTROCARDIOLOGY	390,453		390,453	0	390,453	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,327		186,327	0	186,327	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	994,225		994,225	0	994,225	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,351,517		4,351,517	0	4,351,517	88.00	
90.00	09000	CLINIC	2,547,511		2,547,511	0	2,547,511	90.00	
90.02	09002	GEROPSYCH	507,499		507,499	0	507,499	90.02	
91.00	09100	EMERGENCY	3,468,762		3,468,762	0	3,468,762	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	525,378		525,378		525,378	92.00	
200.00		Subtotal (see instructions)	20,921,231	0	20,921,231	0	20,921,231	200.00	
201.00		Less Observation Beds	525,378		525,378		525,378	201.00	
202.00		Total (see instructions)	20,395,853	0	20,395,853	0	20,395,853	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1333

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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	1,069,049		1,069,049		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,736	931,206	933,942	0.587373	0.000000
53.00	05300	ANESTHESIOLOGY	1,302	381,935	383,237	0.834990	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,692	9,109,219	9,192,911	0.198784	0.000000
60.00	06000	LABORATORY	302,336	6,493,855	6,796,191	0.266018	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	10,529	89,610	100,139	0.533069	0.000000
65.00	06500	RESPIRATORY THERAPY	0	162,127	162,127	0.840181	0.000000
66.00	06600	PHYSICAL THERAPY	107,027	1,229,848	1,336,875	0.446091	0.000000
67.00	06700	OCCUPATIONAL THERAPY	89,790	386,371	476,161	0.762143	0.000000
68.00	06800	SPEECH PATHOLOGY	10,275	412,256	422,531	0.570884	0.000000
69.00	06900	ELECTROCARDIOLOGY	46,093	1,996,688	2,042,781	0.191138	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	158,842	100,161	259,003	0.719401	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	364,407	1,220,243	1,584,650	0.627410	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,623,158	2,623,158	1.658885	0.000000
90.00	09000	CLINIC	4,629	3,959,992	3,964,621	0.642561	0.000000
90.02	09002	GEROPSYCH	0	81,234	81,234	6.247372	0.000000
91.00	09100	EMERGENCY	15,141	2,500,273	2,515,414	1.379002	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,357	373,871	377,228	1.392733	0.000000
200.00		Subtotal (see instructions)	2,269,205	32,052,047	34,321,252		
201.00		Less Observation Beds					
202.00		Total (see instructions)	2,269,205	32,052,047	34,321,252		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1333

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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						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000	CLINIC	0.000000			90.00
90.02	09002	GEROPSYCH	0.000000			90.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet D Part II Date/Time Prepared: 8/24/2020 11:39 am			
				Title XVIII		Hospital		Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	91,383	933,942	0.097847	2,736	268	50.00	
53.00	05300	ANESTHESIOLOGY	961	383,237	0.002508	1,302	3	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,590	9,192,911	0.009093	71,051	646	54.00	
60.00	06000	LABORATORY	43,966	6,796,191	0.006469	122,693	794	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,365	100,139	0.023617	7,810	184	62.00	
65.00	06500	RESPIRATORY THERAPY	16,784	162,127	0.103524	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	44,720	1,336,875	0.033451	6,465	216	66.00	
67.00	06700	OCCUPATIONAL THERAPY	21,978	476,161	0.046157	3,450	159	67.00	
68.00	06800	SPEECH PATHOLOGY	11,590	422,531	0.027430	2,805	77	68.00	
69.00	06900	ELECTROCARDIOLOGY	7,308	2,042,781	0.003577	34,846	125	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,411	259,003	0.125138	85,484	10,697	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	20,475	1,584,650	0.012921	165,059	2,133	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	186,015	2,623,158	0.070913	0	0	88.00	
90.00	09000	CLINIC	187,313	3,964,621	0.047246	104	5	90.00	
90.02	09002	GEROPSYCH	60,206	81,234	0.741143	0	0	90.02	
91.00	09100	EMERGENCY	91,168	2,515,414	0.036244	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	40,225	377,228	0.106633	0	0	92.00	
200.00		Total (lines 50 through 199)	942,458	33,252,203		503,805	15,307	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet D
Part IV
Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	289,069	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.02	09002	GEROPSYCH	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
200.00		Total (lines 50 through 199)	289,069	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet D Part IV Date/Time Prepared: 8/24/2020 11:39 am	
				Title XVIII		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	933,942	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	289,069	0	383,237	0.754283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	9,192,911	0.000000	54.00
60.00	06000	LABORATORY		0	0	0	6,796,191	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	100,139	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	162,127	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	1,336,875	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	476,161	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	422,531	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	2,042,781	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	259,003	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	1,584,650	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	2,623,158	0.000000	88.00
90.00	09000	CLINIC		0	0	0	3,964,621	0.000000	90.00
90.02	09002	GEROPSYCH		0	0	0	81,234	0.000000	90.02
91.00	09100	EMERGENCY		0	0	0	2,515,414	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	377,228	0.000000	92.00
200.00		Total (lines 50 through 199)		0	289,069	0	33,252,203		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part IV
Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	2,736	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,302	982	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	71,051	0	0	0 54.00
60.00	06000	LABORATORY	0.000000	122,693	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	7,810	0	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	6,465	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	3,450	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	2,805	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	34,846	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	85,484	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	165,059	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
90.00	09000	CLINIC	0.000000	104	0	0	0 90.00
90.02	09002	GEROPSYCH	0.000000	0	0	0	0 90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		503,805	982	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part V
Date/Time Prepared:
8/24/2020 11:39 am

			Title XVIII		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.587373	0	314,054	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.834990	0	124,087	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198784	0	3,345,060	0	0	54.00
60.00	06000	LABORATORY	0.266018	0	2,698,486	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.533069	0	68,845	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.840181	0	85,075	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	0	461,230	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.762143	0	50,525	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.570884	0	33,490	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.191138	0	1,036,138	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.719401	0	78,569	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.627410	0	575,385	5,522	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.642561	0	1,787,312	463	0	90.00
90.02	09002	GEROPSYCH	6.247372	0	81,234	0	0	90.02
91.00	09100	EMERGENCY	1.379002	0	851,759	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.392733	0	217,770	0	0	92.00
200.00		Subtotal (see instructions)		0	11,809,019	5,985	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	11,809,019	5,985	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part V
Date/Time Prepared:
8/24/2020 11:39 am

			Title XVIII		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	184,467	0		50.00
53.00	05300	ANESTHESIOLOGY	103,611	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	664,944	0		54.00
60.00	06000	LABORATORY	717,846	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	36,699	0		62.00
65.00	06500	RESPIRATORY THERAPY	71,478	0		65.00
66.00	06600	PHYSICAL THERAPY	205,751	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	38,507	0		67.00
68.00	06800	SPEECH PATHOLOGY	19,119	0		68.00
69.00	06900	ELECTROCARDIOLOGY	198,045	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,523	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,002	3,465		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	1,148,457	298		90.00
90.02	09002	GEROPSYCH	507,499	0		90.02
91.00	09100	EMERGENCY	1,174,577	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	303,295	0		92.00
200.00		Subtotal (see instructions)	5,791,820	3,763		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,791,820	3,763		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1333

Period:

From 03/01/2019

To 02/29/2020

Worksheet D

Part IV

Date/Time Prepared:

8/24/2020 11:39 am

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	289,069	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.02	09002	GEROPSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	289,069	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1333

Period:

From 03/01/2019

To 02/29/2020

Worksheet D

Part IV

Date/Time Prepared:

8/24/2020 11:39 am

			Title XVIII		Swing Beds - SNF	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	933,942	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	289,069	0	383,237	0.754283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,192,911	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,796,191	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	100,139	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	162,127	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,336,875	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	476,161	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	422,531	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,042,781	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	259,003	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,584,650	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,623,158	0.000000	88.00
90.00	09000	CLINIC	0	0	0	3,964,621	0.000000	90.00
90.02	09002	GEROPSYCH	0	0	0	81,234	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	2,515,414	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	377,228	0.000000	92.00
200.00		Total (lines 50 through 199)	0	289,069	0	33,252,203		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1333

Period:

Worksheet D

Component CCN: 14-Z333

From 03/01/2019
To 02/29/2020

Part IV
Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description			Title XVIII		Swing Beds - SNF		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	12,641	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	44,286	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	1,533	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	84,245	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	72,388	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,075	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,876	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	24,303	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	115,709	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.02	09002	GEROPSYCH	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		364,056	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1333

Period:

Worksheet D

Component CCN:14-Z333

From 03/01/2019
To 02/29/2020Part V
Date/Time Prepared:
8/24/2020 11:39 am

				Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.587373	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.834990	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198784	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0.266018	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.533069	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.840181	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.446091	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.762143	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.570884	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.191138	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.719401	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.627410	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000					0	88.00
90.00	09000	CLINIC	0.642561	0	0	0	0	0	90.00
90.02	09002	GEROPSYCH	6.247372	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1.379002	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.392733	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	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	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1333

Period:

Worksheet D

Component CCN:14-Z333

From 03/01/2019
To 02/29/2020Part V
Date/Time Prepared:
8/24/2020 11:39 am

			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.02	09002	GEROPSYCH	0	0	90.02
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet D-1 Date/Time Prepared: 8/24/2020 11:39 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)			1,183	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			720	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)			423	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			367	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)			73	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			19	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)			4	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			315	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)			341	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)			68	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,055,592	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			2,987	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)			629	25.00
26.00	Total swing-bed cost (see instructions)			781,950	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,273,642	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)			1,273,642	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,768.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			557,216	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)			557,216	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet D-1

Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					232,518	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					789,734	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)					603,209	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					120,288	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					723,497	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)					297	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,768.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					525,378	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1333		Period: From 03/01/2019 To 02/29/2020		Worksheet D-1 Date/Time Prepared: 8/24/2020 11:39 am	
		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	157,384	2,055,592	0.076564	525,378	40,225	90.00
91.00	Nursing School cost	0	2,055,592	0.000000	525,378	0	91.00
92.00	Allied health cost	0	2,055,592	0.000000	525,378	0	92.00
93.00	All other Medical Education	0	2,055,592	0.000000	525,378	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet D-3 Date/Time Prepared: 8/24/2020 11:39 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		549,215		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.587373	2,736	1,607	50.00
53.00	05300 ANESTHESIOLOGY	0.834990	1,302	1,087	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.198784	71,051	14,124	54.00
60.00	06000 LABORATORY	0.266018	122,693	32,639	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.533069	7,810	4,163	62.00
65.00	06500 RESPIRATORY THERAPY	0.840181	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.446091	6,465	2,884	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.762143	3,450	2,629	67.00
68.00	06800 SPEECH PATHOLOGY	0.570884	2,805	1,601	68.00
69.00	06900 ELECTROCARDIOLOGY	0.191138	34,846	6,660	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.719401	85,484	61,497	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.627410	165,059	103,560	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.642561	104	67	90.00
90.02	09002 GEROPSYCH	6.247372	0	0	90.02
91.00	09100 EMERGENCY	1.379002	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.392733	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		503,805	232,518	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)		503,805		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet D-3 Date/Time Prepared: 8/24/2020 11:39 am	
		Component CCN: 14-Z333			
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		260,369		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.587373	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.834990	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.198784	12,641	2,513	54.00
60.00	06000 LABORATORY	0.266018	44,286	11,781	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.533069	1,533	817	62.00
65.00	06500 RESPIRATORY THERAPY	0.840181	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.446091	84,245	37,581	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.762143	72,388	55,170	67.00
68.00	06800 SPEECH PATHOLOGY	0.570884	7,075	4,039	68.00
69.00	06900 ELECTROCARDIOLOGY	0.191138	1,876	359	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.719401	24,303	17,484	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.627410	115,709	72,597	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.642561	0	0	90.00
90.02	09002 GEROPSYCH	6.247372	0	0	90.02
91.00	09100 EMERGENCY	1.379002	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.392733	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		364,056	202,341	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)		364,056		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet E Part B Date/Time Prepared: 8/24/2020 11:39 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,795,583	1.00
2.00	Medical and other services reimbursed under OPPIs (see instructions)		0	2.00
3.00	OPPIs payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,795,583	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,853,539	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)		35,371	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,820,717	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,997,451	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,997,451	30.00
31.00	Primary payer payments		5,812	31.00
32.00	Subtotal (line 30 minus line 31)		3,991,639	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)		303,021	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		196,964	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		303,021	36.00
37.00	Subtotal (see instructions)		4,188,603	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)		4,188,603	40.00
40.01	Sequestration adjustment (see instructions)		83,772	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		4,487,097	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)		-382,266	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet E-1
Part I
Date/Time Prepared:
8/24/2020 11:39 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		483,118		4,231,897	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	10/30/2019	67,200	10/30/2019	255,200	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)		67,200		255,200	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)		550,318		4,487,097	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		139,946		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		382,266	6.02
7.00	Total Medicare program liability (see instructions)		690,264		4,104,831	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:14-1333

Period:

Worksheet E-1

Component CCN:14-Z333

From 03/01/2019
To 02/29/2020Part I
Date/Time Prepared:
8/24/2020 11:39 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		760,464		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	10/30/2019	38,300		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)		38,300		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)		798,764		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		112,283		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		911,047		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: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet E-1 Part II Date/Time Prepared: 8/24/2020 11:39 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet E-2	
		Component CCN:14-Z333		Date/Time Prepared: 8/24/2020 11:39 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)		730,732	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)		204,364	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		409	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)		935,096	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		935,096	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)		935,096	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		5,456	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		929,640	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		929,640	0	19.00
19.01	Sequestration adjustment (see instructions)		18,593	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		798,764	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)		112,283	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: 14-1333	Period: From 03/01/2019 To 02/29/2020	Worksheet E-3 Part V Date/Time Prepared: 8/24/2020 11:39 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		789,734	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)		789,734	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		797,631	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)		797,631	19.00
20.00	Deductibles (exclude professional component)		108,483	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		689,148	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		689,148	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23,389	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		15,203	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,389	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		704,351	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)		704,351	30.00
30.01	Sequestration adjustment (see instructions)		14,087	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		550,318	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)		139,946	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet G

Date/Time Prepared:
8/24/2020 11:39 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	10,263,741	0	0	0	1.00
2.00	Temporary investments	167,444	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,901,777	0	0	0	4.00
5.00	Other receivable	1,156,734	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	506,461	0	0	0	7.00
8.00	Prepaid expenses	52,829	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)	15,048,986	0	0	0	11.00
FIXED ASSETS						
12.00	Land	389,864	0	0	0	12.00
13.00	Land improvements	1,052,278	0	0	0	13.00
14.00	Accumulated depreciation	-772,368	0	0	0	14.00
15.00	Buildings	5,400,968	0	0	0	15.00
16.00	Accumulated depreciation	-6,801,464	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	12,023,819	0	0	0	19.00
20.00	Accumulated depreciation	-6,415,301	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,877,796	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	5,122,923	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,838,750	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,961,673	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	26,888,455	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	376,783	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,124,732	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	51,615	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	299,437	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,852,567	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	376,348	0	0	0	47.00
48.00	Unsecured loans	2,157,345	0	0	0	48.00
49.00	Other long term liabilities	3,654,849	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,188,542	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,041,109	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	18,847,346				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	18,847,346	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	26,888,455	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet G-1

Date/Time Prepared:
8/24/2020 11:39 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		18,655,678		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,177,005				2.00
3.00	Total (sum of line 1 and line 2)		19,832,683		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,832,683		0		11.00
12.00	PRIOR PERIOD ADJUSTMENT	973,944		0		0	12.00
13.00	ADJUSTMENT	11,393		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)		985,337		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,847,346		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	PRIOR PERIOD ADJUSTMENT		0				12.00
13.00	ADJUSTMENT		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: 14-1333

Period:
From 03/01/2019
To 02/29/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/24/2020 11:39 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,031,742		1,031,742	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	323,627		323,627	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)	1,355,369		1,355,369	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)	1,355,369		1,355,369	17.00
18.00	Ancillary services	1,129,842	22,801,549	23,931,391	18.00
19.00	Outpatient services	25,162	9,105,536	9,130,698	19.00
20.00	RURAL HEALTH CLINIC	0	2,624,002	2,624,002	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	CULBERTSON GARDENS	0	323,998	323,998	27.00
27.01	DIETARY	0	14,475	14,475	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,510,373	34,869,560	37,379,933	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		23,113,733		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	PATIENT COLLECT FEES-OTHER REV	65,161			37.00
38.00	INTEREST EXPENSE	24,454			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)		89,615		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,024,118		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1333

Period:
From 03/01/2019
To 02/29/2020

Worksheet G-3

Date/Time Prepared:
8/24/2020 11:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	37,379,933	1.00
2.00	Less contractual allowances and discounts on patients' accounts	15,742,215	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,637,718	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,024,118	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,386,400	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	65,038	6.00
7.00	Income from investments	114,843	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,172,464	24.00
24.01	PROPERTY TAXES	690,105	24.01
24.02	NONCAPITAL GRANTS AND GIFTS	58,437	24.02
24.03	LOSS ON DISPOSAL OF ASSETS	486,972	24.03
25.00	Total other income (sum of lines 6-24)	2,587,859	25.00
26.00	Total (line 5 plus line 25)	1,201,459	26.00
27.00	INTEREST EXPENSE	24,454	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	24,454	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,177,005	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1333

Period:

Worksheet M-1

Component CCN: 14-3483

From 03/01/2019

Date/Time Prepared:

To 02/29/2020

8/24/2020 11:39 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	602,987	100,312	703,299	0	703,299
2.00	Physician Assistant	79,211	0	79,211	0	79,211
3.00	Nurse Practitioner	563,149	0	563,149	0	563,149
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	569,944	0	569,944	0	569,944
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	15,106	0	15,106	0	15,106
8.00	Laboratory Technician	82,067	0	82,067	-82,066	1
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	1,912,464	100,312	2,012,776	-82,066	1,930,710
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	116,740	116,740	0	116,740
14.00	Subtotal (sum of lines 11 through 13)	0	116,740	116,740	0	116,740
15.00	Medical Supplies	0	142,409	142,409	0	142,409
16.00	Transportation (Health Care Staff)	0	10,005	10,005	0	10,005
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	152,414	152,414	0	152,414
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,912,464	369,466	2,281,930	-82,066	2,199,864
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0
30.00	Administrative Costs	398,780	87,905	486,685	-77,436	409,249
31.00	Total Facility Overhead (sum of lines 29 and 30)	398,780	87,905	486,685	-77,436	409,249
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,311,244	457,371	2,768,615	-159,502	2,609,113

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1333

Period:

Worksheet M-1

Component CCN: 14-3483

From 03/01/2019
To 02/29/2020Date/Time Prepared:
8/24/2020 11:39 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	-100,312	602,987	1.00
2.00	Physician Assistant	0	79,211	2.00
3.00	Nurse Practitioner	0	563,149	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	569,944	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	15,106	7.00
8.00	Laboratory Technician	0	1	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-100,312	1,830,398	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	116,740	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	116,740	14.00
15.00	Medical Supplies	0	142,409	15.00
16.00	Transportation (Health Care Staff)	0	10,005	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	152,414	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-100,312	2,099,552	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	0	29.00
30.00	Administrative Costs	-4,789	404,460	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,789	404,460	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-105,101	2,504,012	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1333

Period:

Worksheet M-2

Component CCN: 14-3483

From 03/01/2019
To 02/29/2020Date/Time Prepared:
8/24/2020 11:39 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	1.81	4,033	4,200	7,602	1.00
2.00	Physician Assistant	0.68	3,312	2,100	1,428	2.00
3.00	Nurse Practitioner	4.89	5,549	2,100	10,269	3.00
4.00	Subtotal (sum of lines 1 through 3)	7.38	12,894		19,299	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	0.27	2,309		2,309	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)	7.65	15,203		21,608	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				2,099,552	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)				2,099,552	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)				404,460	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,847,505	15.00
16.00	Total overhead (sum of lines 14 and 15)				2,251,965	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				2,251,965	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				2,251,965	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				4,351,517	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1333 Component CCN: 14-3483	Period: From 03/01/2019 To 02/29/2020	Worksheet M-3 Date/Time Prepared: 8/24/2020 11:39 am		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,351,517	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			62,995	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			4,288,522	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,608	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)			21,608	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			198.47	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			198.47	198.47	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,776	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	749,423	11.00	
12.00	Program covered visits for mental health services (from contractor records)		0	36	12.00	
13.00	Program covered cost from mental health services (line 9 x line 12)		0	7,145	13.00	
14.00	Limit adjustment for mental health services (see instructions)		0	7,145	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	756,568	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			560,513	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			632	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			853	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.)			545,569	16.04	
16.05	Total program cost (see instructions)		0	546,422	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			73,754	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			97,226	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			546,422	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			21,556	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			567,978	22.00	
23.00	Allowable bad debts (see instructions)			0	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00	
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00	
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50	
25.99	Demonstration payment adjustment amount before sequestration			0	25.99	
26.00	Net reimbursable amount (see instructions)			567,978	26.00	
26.01	Sequestration adjustment (see instructions)			11,360	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			667,907	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)			-111,289	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:14-1333 Component CCN:14-3483	Period: From 03/01/2019 To 02/29/2020	Worksheet M-4 Date/Time Prepared: 8/24/2020 11:39 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)		1,830,398	1,830,398	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000521	0.001732	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		954	3,170	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		4,659	21,612	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		5,613	24,782	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,099,552	2,099,552	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,251,965	2,251,965	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.002673	0.011803	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		6,020	26,580	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		11,633	51,362	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		235	782	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		49.50	65.68	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		52	289	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,574	18,982	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			62,995	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			21,556	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1333 Component CCN:14-3483	Period: From 03/01/2019 To 02/29/2020	Worksheet M-5 Date/Time Prepared: 8/24/2020 11:39 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		667,907	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		667,907		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		6.01
6.02	SETTLEMENT TO PROGRAM		111,289		6.02
7.00	Total Medicare program liability (see instructions)		556,618		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00