

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: 14-1338

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

Worksheet S
Parts I-III
Date/Time Prepared:
11/25/2020 9:01 am

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/25/2020	Time: 9:01 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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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 MEMORIAL HOSPITAL (14-1338) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-101,180	206,603	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	-314,616	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		137,732		0	10.00
10.01	RURAL HEALTH CLINIC II	0		0		0	10.01
200.00	Total	0	-415,796	344,335	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: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 9:01 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1900 STATE STREET			PO Box:				1.00	
2.00	City: CHESTER			State: IL		Zip Code: 62233		County: RANDOLPH 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		MEMORIAL HOSPITAL	141338	99914	1	09/01/2004	N	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		MEMORIAL HOSPITAL-SWING BEDS	142338	99914		09/01/2004	N	O
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		CHESTER CLINIC	148543	99914		06/01/2015	N	O
15.01	Hospital-Based Health Clinic - RHC II		STEELEVILLE FAMILY PRACTICE	148542	99914		06/01/2015	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	
21.00	Type of Control (see instructions)						8		
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1338

Period:
From 07/01/2019
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Part I
Date/Time Prepared:
11/25/2020 9:01 am

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

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06	
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
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	

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		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)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			Y	Y	Y	N
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			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	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			278,237	0		0118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N			122.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 9:01 am	
			1.00			2.00		
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	Removed and reserved							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N				140.00
			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
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	Title XIX		
			1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital		N	N	N	N		155.00
156.00	Subprovider - IPF		N	N	N	N		156.00
157.00	Subprovider - IRF		N	N	N	N		157.00
158.00	SUBPROVIDER							158.00
159.00	SNF		N	N	N	N		159.00
160.00	HOME HEALTH AGENCY		N	N	N	N		160.00
161.00	CMHC			N	N	N		161.00
								1.00
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N		165.00
			Name	County	State	Zip Code	CBSA	FTE/Campus
			0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.00
								1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							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: 14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 9:01 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: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 9:01 am	
		Y/N		Date			
		1.00		2.00			
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	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	11/02/2020	Y	11/02/2020		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: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/25/2020 9:01 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		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314.231.5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 9:01 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	25	9,150	32,088.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	32,088.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	32,088.00	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)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 9:01 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)	769	22	1,337		1.00
2.00	HMO and other (see instructions)	162	40			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	328	0	562		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	62		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,097	22	1,961		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,097	22	1,961	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RHC (CONSOLIDATED)	5,797	367	19,888	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		10	187		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 9:01 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	207	6	365	1.00
2.00 HMO and other (see instructions)			45	11		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	207	6	365	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

MCRIF32 - 16.4.169.4

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1338 Component CCN: 14-8543		Period: From 07/01/2019 To 06/30/2020		Worksheet S-8 Date/Time Prepared: 11/25/2020 9:01 am	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)								
	CLINIC	08:00	17:00						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1338

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

Worksheet S-10

Date/Time Prepared:
11/25/2020 9:01 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)		0.532757	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,520,302	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		4,145,892	6.00
7.00	Medicaid cost (line 1 times line 6)		2,208,753	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)		688,451	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)		688,451	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)	51,536	153,330	204,866
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	27,456	153,330	180,786
22.00	Payments received from patients for amounts previously written off as charity care	5,504	12,143	17,647
23.00	Cost of charity care (line 21 minus line 22)	21,952	141,187	163,139
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		565,781	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		197,508	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		303,858	27.01
28.00	Non-Medicare bad debt expense (see instructions)		261,923	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		245,891	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		409,030	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,097,481	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1338

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

Worksheet A

Date/Time Prepared:
11/25/2020 9:01 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		1,276,680	1,276,680	-644,291	632,389	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	834,924	834,924	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	167,591	2,813,654	2,981,245	0	2,981,245	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,409,689	1,299,303	2,708,992	462,174	3,171,166	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	483,867	483,164	967,031	0	967,031	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	54,557	51,383	105,940	0	105,940	8.00
9.00	00900	HOUSEKEEPING	309,793	85,067	394,860	0	394,860	9.00
10.00	01000	DIETARY	369,184	195,554	564,738	-420,185	144,553	10.00
11.00	01100	CAFETERIA	0	0	0	420,185	420,185	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	295,582	49,100	344,682	0	344,682	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,493	662,144	730,637	-640,793	89,844	14.00
15.00	01500	PHARMACY	352,972	747,442	1,100,414	-642,042	458,372	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	476,085	71,773	547,858	0	547,858	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,626,159	184,368	1,810,527	120,483	1,931,010	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	686,711	218,843	905,554	-66,121	839,433	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	689,292	692,179	1,381,471	0	1,381,471	54.00
60.00	06000	LABORATORY	709,358	790,258	1,499,616	-19,014	1,480,602	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,045	57,544	79,589	0	79,589	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	56,892	56,892	64.00
65.00	06500	RESPIRATORY THERAPY	223,581	96,357	319,938	-1,156	318,782	65.00
66.00	06600	PHYSICAL THERAPY	0	444,547	444,547	0	444,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	81,245	81,245	0	81,245	67.00
68.00	06800	SPEECH PATHOLOGY	0	53,563	53,563	0	53,563	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	455,269	455,269	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	185,524	185,524	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	642,042	642,042	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	239,614	1,126,137	1,365,751	-42,199	1,323,552	76.01
76.02	03020	WOUND CARE	0	40,390	40,390	0	40,390	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,948,206	2,231,278	5,179,484	-700,027	4,479,457	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	203,398	110,874	314,272	0	314,272	90.00
91.00	09100	EMERGENCY	833,567	1,793,365	2,626,932	-1,665	2,625,267	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)	12,169,744	15,656,212	27,825,956	0	27,825,956	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,266	254	3,520	0	3,520	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	12,173,010	15,656,466	27,829,476	0	27,829,476	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1338

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

Worksheet A

Date/Time Prepared:
11/25/2020 9:01 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	632,389	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,710	833,214	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,981,245	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-228,969	2,942,197	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-2,481	964,550	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	105,940	8.00
9.00	00900	HOUSEKEEPING	0	394,860	9.00
10.00	01000	DIETARY	-1,035	143,518	10.00
11.00	01100	CAFETERIA	-51,045	369,140	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	344,682	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-320	89,524	14.00
15.00	01500	PHARMACY	-120,391	337,981	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,301	533,557	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-133,390	1,797,620	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	839,433	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-200	1,381,271	54.00
60.00	06000	LABORATORY	0	1,480,602	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	79,589	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	56,892	64.00
65.00	06500	RESPIRATORY THERAPY	-44,888	273,894	65.00
66.00	06600	PHYSICAL THERAPY	0	444,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	81,245	67.00
68.00	06800	SPEECH PATHOLOGY	0	53,563	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	455,269	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	185,524	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-65,419	576,623	73.00
76.00	03950	CARDIAC REHAB	0	0	76.00
76.01	03951	CHEMOTHERAPY	-161,525	1,162,027	76.01
76.02	03020	WOUND CARE	0	40,390	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-1,067,143	3,412,314	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
90.00	09000	CLINIC	-78,064	236,208	90.00
91.00	09100	EMERGENCY	-1,181,700	1,443,567	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)	-3,152,581	24,673,375	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	3,520	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,152,581	24,676,895	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS DRUG COST				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	642,042	1.00
	0		0	642,042	
	B - RECLASS DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	747,213	1.00
	0		0	747,213	
	C - RECLASS MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	455,269	1.00
	PATIENT				
2.00	IMPL. DEV. CHARGED TO	72.00	0	185,524	2.00
	PATIENTS				
	0		0	640,793	
	F - CAFETERIA				
1.00	CAFETERIA	11.00	274,686	145,499	1.00
	0		274,686	145,499	
	H - LEASE/RENTAL				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	87,711	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	87,711	
	I - RHC ADMINISTRATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	337,794	228,843	1.00
	0		337,794	228,843	
	L - RECLASS PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	102,922	1.00
	0		0	102,922	
	M - TO RECLASS IV THERAPY EXPENSE				
1.00	INTRAVENOUS THERAPY	64.00	53,002	3,890	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		53,002	3,890	
	N - TO RECLASS RHC HOSPITALIST EXPENSE				
1.00	ADULTS & PEDIATRICS	30.00	112,262	21,128	1.00
	TOTALS		112,262	21,128	
500.00	Grand Total: Increases		777,744	2,620,041	500.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RECLASS DRUG COST						
	PHARMACY _____	15.00	0	642,042	0		1.00
	0		0	642,042			
1.00	B - RECLASS DEPRECIATION						
	CAP REL COSTS-BLDG & FIXT _____	1.00	0	747,213	9		1.00
	0		0	747,213			
1.00	C - RECLASS MEDICAL SUPPLIES						
	CENTRAL SERVICES & SUPPLY _____	14.00	0	640,793	0		1.00
2.00	_____	0.00	0	0	0		2.00
	0		0	640,793			
1.00	F - CAFETERIA						
	DIETARY _____	10.00	274,686	145,499	0		1.00
	0		274,686	145,499			
1.00	H - LEASE/RENTAL						
	ADMINISTRATIVE & GENERAL _____	5.00	0	1,541	10		1.00
2.00	OPERATING ROOM _____	50.00	0	66,000	0		2.00
3.00	LABORATORY _____	60.00	0	19,014	0		3.00
4.00	RESPIRATORY THERAPY _____	65.00	0	1,156	0		4.00
	0		0	87,711			
1.00	I - RHC ADMINISTRATION						
	RURAL HEALTH CLINIC _____	88.00	337,794	228,843	0		1.00
	0		337,794	228,843			
1.00	L - RECLASS PROPERTY INSURANCE						
	ADMINISTRATIVE & GENERAL _____	5.00	0	102,922	12		1.00
	0		0	102,922			
1.00	M - TO RECLASS IV THERAPY EXPENSE						
	EMERGENCY _____	91.00	1,548	117	0		1.00
2.00	ADULTS & PEDIATRICS _____	30.00	12,006	901	0		2.00
3.00	CHEMOTHERAPY _____	76.01	39,335	2,864	0		3.00
4.00	OPERATING ROOM _____	50.00	113	8	0		4.00
	TOTALS _____		53,002	3,890			
1.00	N - TO RECLASS RHC HOSPITALIST EXPENSE						
	RURAL HEALTH CLINIC _____	88.00	112,262	21,128	0		1.00
	TOTALS _____		112,262	21,128			
500.00	Grand Total: Decreases		777,744	2,620,041			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/25/2020 9:01 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	232,983	0	0	0	0	1.00	
2.00	Land Improvements	699,764	0	0	0	0	2.00	
3.00	Buildings and Fixtures	17,433,598	3,385,267	0	3,385,267	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	1,000,778	0	0	0	0	5.00	
6.00	Movable Equipment	12,309,391	513,228	0	513,228	545,207	6.00	
7.00	HIT designated Assets	1,560,155	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	33,236,669	3,898,495	0	3,898,495	545,207	8.00	
9.00	Reconciling Items	1,012,434	2,383,479	0	2,383,479	0	9.00	
10.00	Total (line 8 minus line 9)	32,224,235	1,515,016	0	1,515,016	545,207	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	232,983	0					1.00
2.00	Land Improvements	699,764	0					2.00
3.00	Buildings and Fixtures	20,818,865	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	1,000,778	0					5.00
6.00	Movable Equipment	12,277,412	0					6.00
7.00	HIT designated Assets	1,560,155	0					7.00
8.00	Subtotal (sum of lines 1-7)	36,589,957	0					8.00
9.00	Reconciling Items	3,395,913	0					9.00
10.00	Total (line 8 minus line 9)	33,194,044	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/25/2020 9:01 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	1,276,680	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,276,680	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,276,680				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,276,680				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	22,752,390	0	22,752,390	0.621821	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,837,567	0	13,837,567	0.378179	0	2.00
3.00	Total (sum of lines 1-2)	36,589,957	0	36,589,957	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	529,467	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	745,503	87,711	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,274,970	87,711	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	102,922	0	0	632,389	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	833,214	2.00
3.00	Total (sum of lines 1-2)	0	102,922	0	0	1,465,603	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1338

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

Worksheet A-8

Date/Time Prepared:
11/25/2020 9:01 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 #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-120,391	PHARMACY	15.00	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	-2,456	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,599,567			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-2,481	OPERATION OF PLANT	7.00	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	-49,045	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-65,419	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-14,301	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			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)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1338

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

Worksheet A-8

Date/Time Prepared:
11/25/2020 9:01 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 #		
				3.00	4.00		
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-1,710	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
35.00	NON ALLOW LOBBYING DUES	A	-8,906	ADMINISTRATIVE & GENERAL	5.00	0	35.00
35.01	NON ALLOW SALARY	A	-951	ADMINISTRATIVE & GENERAL	5.00	0	35.01
35.02	NON ALLOW OTHER	A	-50,210	ADMINISTRATIVE & GENERAL	5.00	0	35.02
40.00	CRNA AND SURGEON BILLING EXPENSE	A	-137,306	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	RHC CRNA EXPENSE	A	-607,510	RURAL HEALTH CLINIC	88.00	0	41.00
42.00	RHC SURGEON	A	-379,624	RURAL HEALTH CLINIC	88.00	0	42.00
44.01	RHC PHYSICIAN FEES	A	-760	RURAL HEALTH CLINIC	88.00	0	44.01
45.00	NON ALLOW DR MEALS	B	-1,035	DIETARY	10.00	0	45.00
45.01	MISC REV PET SCANNER	B	-200	RADIOLOGY-DIAGNOSTIC	54.00	0	45.01
45.02	MISC REV	B	-29,140	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	MISC REV	B	-2,000	CAFETERIA	11.00	0	45.03
45.04	MISC REV	B	-320	CENTRAL SERVICES & SUPPLY	14.00	0	45.04
45.05	MISC REV	B	-1,500	RURAL HEALTH CLINIC	88.00	0	45.05
45.06	RHC LAB CHARGES	A	-77,749	RURAL HEALTH CLINIC	88.00	0	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,152,581				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: 14-1338

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

Worksheet A-8-2

Date/Time Prepared:
11/25/2020 9:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	133,390	133,390	0	0	0	1.00
2.00	90.00	AGGREGATE-CLINIC	78,064	78,064	0	0	0	2.00
3.00	91.00	AGGREGATE-EMERGENCY	1,699,943	1,181,700	518,243	0	0	3.00
4.00	76.01	AGGREGATE-CHEMOTHERAPY	161,525	161,525	0	0	0	4.00
5.00	60.00	AGGREGATE-LABORATORY	22,652	0	22,652	0	0	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	44,263	44,263	0	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	625	625	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,140,462	1,599,567	540,895		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	2.00
3.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	3.00
4.00	76.01	AGGREGATE-CHEMOTHERAPY	0	0	0	0	0	4.00
5.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	133,390		1.00
2.00	90.00	AGGREGATE-CLINIC	0	0	0	78,064		2.00
3.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,181,700		3.00
4.00	76.01	AGGREGATE-CHEMOTHERAPY	0	0	0	161,525		4.00
5.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		5.00
6.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	44,263		6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	625		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,599,567		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2020 9:01 am		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.50	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	3,517.30	4,957.80	2,532.40	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	84.70	63.52	42.35	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.35	42.35	31.76			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)						297,915	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						314,919	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						612,834	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						107,247	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)						720,081	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)						720,081	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2020 9:01 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)	84.70	63.52	42.35	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)						720,081	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						720,081	63.00
64.00	Total cost of outside supplier services (from your records)						432,060	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2020 9:01 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	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	1,116.30	945.60	64.30	0.00	0.00	9.00
10.00	AHSEA (see instructions)	100.36	80.29	60.22	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.15	40.15	30.11			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)					112,032	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					75,922	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					3,872	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					191,826	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)					191,826	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)					191,826	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2020 9:01 am		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.29	60.22	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						191,826	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						191,826	63.00
64.00	Total cost of outside supplier services (from your records)						81,245	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2020 9:01 am		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.50	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	372.90	841.60	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	96.44	77.15	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.58	38.58	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						35,962	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						64,929	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)						100,891	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)						100,891	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)						100,891	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						0	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						0	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2020 9:01 am		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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)	77.15	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)						100,891	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						100,891	63.00
64.00	Total cost of outside supplier services (from your records)						25,144	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	632,389	632,389			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	833,214		833,214		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,981,245	4,177	5,503	2,990,925	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,942,197	135,849	178,992	549,502	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	964,550	90,503	119,244	152,237	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	105,940	5,073	6,685	17,165	8.00
9.00	00900	HOUSEKEEPING	394,860	7,443	9,806	97,469	9.00
10.00	01000	DIETARY	143,518	3,067	4,041	29,731	10.00
11.00	01100	CAFETERIA	369,140	17,405	22,932	86,423	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	344,682	9,329	12,291	92,997	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	89,524	8,539	11,250	21,550	14.00
15.00	01500	PHARMACY	337,981	5,614	7,397	111,054	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	533,557	11,954	15,750	149,788	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,797,620	54,818	72,227	543,173	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	839,433	61,108	80,514	216,021	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,381,271	35,841	47,223	216,868	54.00
60.00	06000	LABORATORY	1,480,602	20,372	26,841	223,182	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	79,589	1,025	1,350	6,936	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	56,892	0	0	16,676	64.00
65.00	06500	RESPIRATORY THERAPY	273,894	10,723	14,128	70,344	65.00
66.00	06600	PHYSICAL THERAPY	444,547	68,203	89,862	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,245	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	53,563	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	455,269	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,524	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	576,623	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	1,162,027	17,405	22,932	63,013	76.01
76.02	03020	WOUND CARE	40,390	669	881	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,412,314	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	236,208	19,511	25,707	63,994	90.00
91.00	09100	EMERGENCY	1,443,567	30,021	39,554	261,774	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)	24,673,375	618,649	815,110	2,989,897	24,640,503
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,520	6,205	8,175	1,028	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	3,202	4,219	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	4,333	5,710	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	24,676,895	632,389	833,214	2,990,925	24,676,895

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,806,540					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	241,947	0	1,568,481			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,598	0	19,802	179,263		8.00
9.00	00900	HOUSEKEEPING	92,942	0	29,050	0	631,570	9.00
10.00	01000	DIETARY	32,895	0	11,970	0	4,975	10.00
11.00	01100	CAFETERIA	90,447	0	67,932	0	28,233	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	83,772	0	36,410	0	15,132	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,868	0	33,327	0	13,851	14.00
15.00	01500	PHARMACY	84,273	0	21,913	0	9,107	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	129,688	0	46,658	0	19,391	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	450,109	0	213,960	179,263	88,923	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	218,335	0	238,510	0	99,127	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	306,635	0	139,890	0	58,139	54.00
60.00	06000	LABORATORY	319,364	0	79,513	0	33,046	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,214	0	3,999	0	1,662	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	13,418	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	67,318	0	41,853	0	17,395	65.00
66.00	06600	PHYSICAL THERAPY	109,910	0	266,198	0	110,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,818	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,769	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,037	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,838	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,170	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	230,792	0	67,932	0	28,233	76.01
76.02	03020	WOUND CARE	7,649	0	2,611	0	1,085	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	622,368	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	63,001	0	76,152	0	31,649	90.00
91.00	09100	EMERGENCY	323,727	0	117,172	0	48,698	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)	3,799,902	0	1,514,852	179,263	609,282	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,452	0	24,218	0	10,065	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,354	0	12,498	0	5,194	192.00
193.01	19301	AFTER CARE PROGRAM	1,832	0	16,913	0	7,029	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,806,540	0	1,568,481	179,263	631,570	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1338

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	230,197					10.00
11.00	01100	CAFETERIA	0	682,512				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	30,836	0	625,449		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,145	0	0	209,054	14.00
15.00	01500	PHARMACY	0	36,823	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	49,666	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	230,197	180,100	0	313,408	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	71,627	0	124,642	8,837	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,908	0	0	1,965	54.00
60.00	06000	LABORATORY	0	74,002	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,300	0	0	190	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	5,529	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	23,324	0	0	991	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	81	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	134,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	53,044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	20,894	0	36,358	2,080	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	3,915	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	21,219	0	0	430	90.00
91.00	09100	EMERGENCY	0	86,798	0	151,041	2,847	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)	230,197	682,171	0	625,449	209,054	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	341	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	230,197	682,512	0	625,449	209,054	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	614,162					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	956,452				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	50,038	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	51,249	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	219,589	0	0	0	54.00
60.00	06000	LABORATORY	0	214,627	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,927	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	7,586	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	34,909	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	46,645	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,853	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,432	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	99,724	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,345	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	227,250	58,751	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	329,870	67,732	0	0	0	76.01
76.02	03020	WOUND CARE	0	2,326	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	57,042	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	7,957	0	0	0	90.00
91.00	09100	EMERGENCY	0	68,762	0	0	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)	614,162	956,452	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	614,162	956,452	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	4,173,836	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,009,403	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,479,329	0	54.00
60.00	06000	LABORATORY	0	0	0	2,471,549	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	118,192	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	100,101	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	554,879	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,136,082	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	103,916	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	67,764	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	772,704	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	281,751	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	967,794	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	0	0	2,049,268	0	76.01
76.02	03020	WOUND CARE	0	0	0	55,611	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,095,639	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	545,828	0	90.00
91.00	09100	EMERGENCY	0	0	0	2,573,961	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)	0	0	0	24,557,607	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	57,004	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	26,467	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	35,817	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	24,676,895	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		4,173,836	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	CARDIAC REHAB	76.00
76.01	03951	CHEMOTHERAPY	76.01
76.02	03020	WOUND CARE	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	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)		118.00
		24,557,607	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
193.01	19301	AFTER CARE PROGRAM	193.01
194.00	07950	NON-ALLOWABLE COSTS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		24,676,895	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,177	5,503	9,680	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	135,849	178,992	314,841	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	90,503	119,244	209,747	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,073	6,685	11,758	8.00
9.00	00900	HOUSEKEEPING	0	7,443	9,806	17,249	9.00
10.00	01000	DIETARY	0	3,067	4,041	7,108	10.00
11.00	01100	CAFETERIA	0	17,405	22,932	40,337	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	9,329	12,291	21,620	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,539	11,250	19,789	14.00
15.00	01500	PHARMACY	0	5,614	7,397	13,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,954	15,750	27,704	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	54,818	72,227	127,045	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	61,108	80,514	141,622	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,841	47,223	83,064	54.00
60.00	06000	LABORATORY	0	20,372	26,841	47,213	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,025	1,350	2,375	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,723	14,128	24,851	65.00
66.00	06600	PHYSICAL THERAPY	0	68,203	89,862	158,065	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	17,405	22,932	40,337	76.01
76.02	03020	WOUND CARE	0	669	881	1,550	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	0	19,511	25,707	45,218	90.00
91.00	09100	EMERGENCY	0	30,021	39,554	69,575	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	618,649	815,110	1,433,759	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	6,205	8,175	14,380	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	3,202	4,219	7,421	192.00
193.01	19301	AFTER CARE PROGRAM	0	4,333	5,710	10,043	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	632,389	833,214	1,465,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	316,621					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	20,125	0	230,365			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,046	0	2,908	16,768		8.00
9.00	00900	HOUSEKEEPING	7,731	0	4,267	0	29,562	9.00
10.00	01000	DIETARY	2,736	0	1,758	0	233	10.00
11.00	01100	CAFETERIA	7,523	0	9,977	0	1,322	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,968	0	5,348	0	708	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,985	0	4,895	0	648	14.00
15.00	01500	PHARMACY	7,010	0	3,218	0	426	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,787	0	6,853	0	908	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,440	0	31,425	16,768	4,162	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,161	0	35,030	0	4,640	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,506	0	20,546	0	2,721	54.00
60.00	06000	LABORATORY	26,564	0	11,678	0	1,547	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,349	0	587	0	78	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,116	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,599	0	6,147	0	814	65.00
66.00	06600	PHYSICAL THERAPY	9,142	0	39,097	0	5,179	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,233	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	813	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,907	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,815	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,748	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	19,197	0	9,977	0	1,322	76.01
76.02	03020	WOUND CARE	636	0	383	0	51	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	51,765	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	5,240	0	11,185	0	1,481	90.00
91.00	09100	EMERGENCY	26,927	0	17,209	0	2,279	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)	316,069	0	222,488	16,768	28,519	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	287	0	3,557	0	471	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	113	0	1,836	0	243	192.00
193.01	19301	AFTER CARE PROGRAM	152	0	2,484	0	329	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	316,621	0	230,365	16,768	29,562	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	11,931					10.00
11.00	01100	CAFETERIA	0	59,439				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,685	0	37,630		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	622	0	0	28,009	14.00
15.00	01500	PHARMACY	0	3,207	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,325	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,931	15,685	0	18,857	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,238	0	7,499	1,184	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,262	0	0	263	54.00
60.00	06000	LABORATORY	0	6,445	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	200	0	0	26	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	482	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,031	0	0	133	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	11	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	18,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	7,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0	1,820	0	2,187	279	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	525	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	1,848	0	0	58	90.00
91.00	09100	EMERGENCY	0	7,559	0	9,087	381	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)	11,931	59,409	0	37,630	28,009	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	30	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	11,931	59,439	0	37,630	28,009	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	27,231					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	51,062				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,670	0			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,735	0			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,737	0			54.00
60.00	06000	LABORATORY	0	11,454	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	263	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	0	405	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	1,863	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,489	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	419	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	237	0			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,322	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	499	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,076	3,135	0			73.00
76.00	03950	CARDIAC REHAB	0	0	0			76.00
76.01	03951	CHEMOTHERAPY	14,626	3,615	0			76.01
76.02	03020	WOUND CARE	0	124	0			76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,529	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
90.00	09000	CLINIC	0	425	0			90.00
91.00	09100	EMERGENCY	0	3,670	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)	27,231	51,062	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0			193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0			194.00
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)	27,231	51,062	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				267,740	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				217,808	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				150,801	0	54.00
60.00	06000	LABORATORY				105,623	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				4,900	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				2,057	0	64.00
65.00	06500	RESPIRATORY THERAPY				41,666	0	65.00
66.00	06600	PHYSICAL THERAPY				213,983	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				1,652	0	67.00
68.00	06800	SPEECH PATHOLOGY				1,050	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				30,271	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				10,421	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				21,959	0	73.00
76.00	03950	CARDIAC REHAB				0	0	76.00
76.01	03951	CHEMOTHERAPY				93,564	0	76.01
76.02	03020	WOUND CARE				2,744	0	76.02
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				54,819	0	88.00
88.01	08801	RURAL HEALTH CLINIC II				0	0	88.01
90.00	09000	CLINIC				65,662	0	90.00
91.00	09100	EMERGENCY				137,534	0	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	0	0	1,424,254	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN				18,728	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES				9,613	0	192.00
193.01	19301	AFTER CARE PROGRAM				13,008	0	193.01
194.00	07950	NON-ALLOWABLE COSTS				0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	1,465,603	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		267,740	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	CARDIAC REHAB	76.00
76.01	03951	CHEMOTHERAPY	76.01
76.02	03020	WOUND CARE	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	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)		118.00
		1,424,254	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
193.01	19301	AFTER CARE PROGRAM	193.01
194.00	07950	NON-ALLOWABLE COSTS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		1,465,603	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQ FEET)	MOVBLE EQUIP (SQ FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	88,874					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		88,874				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	587	587	9,506,323			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,092	19,092	1,746,537	-3,806,540	20,870,355	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	12,719	12,719	483,867	0	1,326,534	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	713	713	54,557	0	134,863	8.00
9.00	00900	HOUSEKEEPING	1,046	1,046	309,793	0	509,578	9.00
10.00	01000	DIETARY	431	431	94,498	0	180,357	10.00
11.00	01100	CAFETERIA	2,446	2,446	274,686	0	495,900	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,311	1,311	295,582	0	459,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,200	1,200	68,493	0	130,863	14.00
15.00	01500	PHARMACY	789	789	352,972	0	462,046	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,680	1,680	476,085	0	711,049	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,704	7,704	1,726,415	0	2,467,838	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,588	8,588	686,598	0	1,197,076	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,037	5,037	689,292	0	1,681,203	54.00
60.00	06000	LABORATORY	2,863	2,863	709,358	0	1,750,997	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	144	144	22,045	0	88,900	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	53,002	0	73,568	64.00
65.00	06500	RESPIRATORY THERAPY	1,507	1,507	223,581	0	369,089	65.00
66.00	06600	PHYSICAL THERAPY	9,585	9,585	0	0	602,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	81,245	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	53,563	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	455,269	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	185,524	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	576,623	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,446	2,446	200,279	0	1,265,377	76.01
76.02	03020	WOUND CARE	94	94	0	0	41,940	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	3,412,314	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	2,742	2,742	203,398	0	345,420	90.00
91.00	09100	EMERGENCY	4,219	4,219	832,019	0	1,774,916	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)	86,943	86,943	9,503,057	-3,806,540	20,833,963	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	872	872	3,266	0	18,928	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	450	450	0	0	7,421	192.00
193.01	19301	AFTER CARE PROGRAM	609	609	0	0	10,043	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	632,389	833,214	2,990,925		3,806,540	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.115568	9.375228	0.314625		0.182390	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,680		316,621	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001018		0.015171	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQ FEET)	MVBLE EQUIP (SQ FEET)				
			1.00	2.00	4.00	5A	5.00	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description		MAINTENANCE & REPAIRS (GROSS SALARIES)	OPERATION OF PLANT (SQ FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQ FEET)	DIETARY (PATIENT DA YS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	56,476			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	713	1,337		8.00
9.00	00900	HOUSEKEEPING	0	1,046	0	54,717	9.00
10.00	01000	DIETARY	0	431	0	431	10.00
11.00	01100	CAFETERIA	0	2,446	0	2,446	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	1,311	0	1,311	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,200	0	1,200	0 14.00
15.00	01500	PHARMACY	0	789	0	789	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,680	0	1,680	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	7,704	1,337	7,704	1,337 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	8,588	0	8,588	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,037	0	5,037	0 54.00
60.00	06000	LABORATORY	0	2,863	0	2,863	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	144	0	144	0 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	1,507	0	1,507	0 65.00
66.00	06600	PHYSICAL THERAPY	0	9,585	0	9,585	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0 76.00
76.01	03951	CHEMOTHERAPY	0	2,446	0	2,446	0 76.01
76.02	03020	WOUND CARE	0	94	0	94	0 76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
90.00	09000	CLINIC	0	2,742	0	2,742	0 90.00
91.00	09100	EMERGENCY	0	4,219	0	4,219	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)	0	54,545	1,337	52,786	1,337 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	872	0	872	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	450	0	450	0 192.00
193.01	19301	AFTER CARE PROGRAM	0	609	0	609	0 193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,568,481	179,263	631,570	230,197 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	27.772523	134.078534	11.542482	172.174271 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	230,365	16,768	29,562	11,931 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	4.078989	12.541511	0.540271	8.923710 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: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	6,542,385					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	295,582	0	3,445,311			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,493	0	0	731,183		14.00
15.00	01500	PHARMACY	352,972	0	0	0	1,735,169	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	476,085	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,726,415	0	1,726,415	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	686,598	0	686,598	30,909	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	689,292	0	0	6,871	0	54.00
60.00	06000	LABORATORY	709,358	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	22,045	0	0	666	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	53,002	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	223,581	0	0	3,467	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	283	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	471,033	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	185,524	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	642,042	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	200,279	0	200,279	7,276	931,969	76.01
76.02	03020	WOUND CARE	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	13,694	161,158	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	203,398	0	0	1,503	0	90.00
91.00	09100	EMERGENCY	832,019	0	832,019	9,957	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)	6,539,119	0	3,445,311	731,183	1,735,169	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,266	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	682,512	0	625,449	209,054	614,162	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.104322	0.000000	0.181536	0.285912	0.353949	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	59,439	0	37,630	28,009	27,231	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009085	0.000000	0.010922	0.038306	0.015694	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: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,430,968					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,167,557	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,220,010	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,511,432	0	0	0	0	54.00
60.00	06000	LABORATORY	9,297,268	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	213,431	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	328,604	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,512,196	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,020,570	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	340,176	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	191,997	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,319,876	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	404,787	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,544,990	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	2,934,013	0	0	0	0	76.01
76.02	03020	WOUND CARE	100,737	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	344,700	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,978,624	0	0	0	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)	41,430,968	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	AFTER CARE PROGRAM	0	0	0	0	0	193.01
194.00	07950	NON-ALLOWABLE COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	956,452	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.023085	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	51,062	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001232	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	16.00	17.00	19.00	20.00	21.00	207.00
						0.000000		

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)			
			22.00			23.00
			GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00	
5.00	00500	ADMINISTRATIVE & GENERAL			5.00	
6.00	00600	MAINTENANCE & REPAIRS			6.00	
7.00	00700	OPERATION OF PLANT			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE			8.00	
9.00	00900	HOUSEKEEPING			9.00	
10.00	01000	DIETARY			10.00	
11.00	01100	CAFETERIA			11.00	
12.00	01200	MAINTENANCE OF PERSONNEL			12.00	
13.00	01300	NURSING ADMINISTRATION			13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00	
15.00	01500	PHARMACY			15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00	
17.00	01700	SOCIAL SERVICE			17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00	
20.00	02000	NURSING SCHOOL			20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
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	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00	
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	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.00	03950	CARDIAC REHAB	0	0	76.00	
76.01	03951	CHEMOTHERAPY	0	0	76.01	
76.02	03020	WOUND CARE	0	0	76.02	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01	
90.00	09000	CLINIC	0	0	90.00	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00	
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00	
193.01	19301	AFTER CARE PROGRAM	0	0	193.01	
194.00	07950	NON-ALLOWABLE COSTS	0	0	194.00	
200.00		Cross Foot Adjustments			200.00	
201.00		Negative Cost Centers			201.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1338

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:01 am

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	4,173,836		4,173,836	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,009,403		2,009,403	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,479,329		2,479,329	0
60.00	06000	LABORATORY	2,471,549		2,471,549	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	118,192		118,192	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
64.00	06400	INTRAVENOUS THERAPY	100,101		100,101	0
65.00	06500	RESPIRATORY THERAPY	554,879	0	554,879	0
66.00	06600	PHYSICAL THERAPY	1,136,082	0	1,136,082	0
67.00	06700	OCCUPATIONAL THERAPY	103,916	0	103,916	0
68.00	06800	SPEECH PATHOLOGY	67,764	0	67,764	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	772,704		772,704	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	281,751		281,751	0
73.00	07300	DRUGS CHARGED TO PATIENTS	967,794		967,794	0
76.00	03950	CARDIAC REHAB	0		0	0
76.01	03951	CHEMOTHERAPY	2,049,268		2,049,268	0
76.02	03020	WOUND CARE	55,611		55,611	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,095,639		4,095,639	0
88.01	08801	RURAL HEALTH CLINIC II	0		0	0
90.00	09000	CLINIC	545,828		545,828	0
91.00	09100	EMERGENCY	2,573,961		2,573,961	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	373,280		373,280	0
200.00		Subtotal (see instructions)	24,930,887	0	24,930,887	0
201.00		Less Observation Beds	373,280		373,280	0
202.00		Total (see instructions)	24,557,607	0	24,557,607	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:01 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	1,926,138		1,926,138		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	284,345	1,935,665	2,220,010	0.905132	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	524,185	8,987,247	9,511,432	0.260668	0.000000
60.00	06000	LABORATORY	950,045	8,347,223	9,297,268	0.265836	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	67,975	145,456	213,431	0.553771	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	1,386	327,218	328,604	0.304625	0.000000
65.00	06500	RESPIRATORY THERAPY	258,718	1,253,478	1,512,196	0.366936	0.000000
66.00	06600	PHYSICAL THERAPY	318,878	1,701,692	2,020,570	0.562258	0.000000
67.00	06700	OCCUPATIONAL THERAPY	116,459	223,717	340,176	0.305477	0.000000
68.00	06800	SPEECH PATHOLOGY	20,630	171,367	191,997	0.352943	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	943,283	3,376,593	4,319,876	0.178872	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	222,867	181,920	404,787	0.696048	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	661,589	1,883,401	2,544,990	0.380274	0.000000
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	0.000000
76.01	03951	CHEMOTHERAPY	3,861	2,930,152	2,934,013	0.698452	0.000000
76.02	03020	WOUND CARE	1,313	99,424	100,737	0.552041	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	530,245	4,134,111	4,664,356		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	09000	CLINIC	1,048	343,652	344,700	1.583487	0.000000
91.00	09100	EMERGENCY	19,352	2,959,272	2,978,624	0.864144	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	241,419	241,419	1.546191	0.000000
200.00		Subtotal (see instructions)	6,852,317	39,243,007	46,095,324		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,852,317	39,243,007	46,095,324		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	CARDIAC REHAB	0.000000			76.00
76.01	03951	CHEMOTHERAPY	0.000000			76.01
76.02	03020	WOUND CARE	0.000000			76.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:01 am

			Title XIX	Hospital	Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,173,836		4,173,836	0	4,173,836 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,009,403		2,009,403	0	2,009,403 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,479,329		2,479,329	0	2,479,329 54.00
60.00	06000 LABORATORY	2,471,549		2,471,549	0	2,471,549 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	118,192		118,192	0	118,192 62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
64.00	06400 INTRAVENOUS THERAPY	100,101		100,101	0	100,101 64.00
65.00	06500 RESPIRATORY THERAPY	554,879	0	554,879	0	554,879 65.00
66.00	06600 PHYSICAL THERAPY	1,136,082	0	1,136,082	0	1,136,082 66.00
67.00	06700 OCCUPATIONAL THERAPY	103,916	0	103,916	0	103,916 67.00
68.00	06800 SPEECH PATHOLOGY	67,764	0	67,764	0	67,764 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	772,704		772,704	0	772,704 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	281,751		281,751	0	281,751 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	967,794		967,794	0	967,794 73.00
76.00	03950 CARDIAC REHAB	0		0	0	0 76.00
76.01	03951 CHEMOTHERAPY	2,049,268		2,049,268	0	2,049,268 76.01
76.02	03020 WOUND CARE	55,611		55,611	0	55,611 76.02
76.97	07697 CARDIAC REHABILITATION	0		0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98
76.99	07699 LITHOTRIPSY	0		0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	4,095,639		4,095,639	0	4,095,639 88.00
88.01	08801 RURAL HEALTH CLINIC II	0		0	0	0 88.01
90.00	09000 CLINIC	545,828		545,828	0	545,828 90.00
91.00	09100 EMERGENCY	2,573,961		2,573,961	0	2,573,961 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	373,280		373,280	0	373,280 92.00
200.00	Subtotal (see instructions)	24,930,887	0	24,930,887	0	24,930,887 200.00
201.00	Less Observation Beds	373,280		373,280	0	373,280 201.00
202.00	Total (see instructions)	24,557,607	0	24,557,607	0	24,557,607 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:01 am

			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	1,926,138		1,926,138		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	284,345	1,935,665	2,220,010	0.905132	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	524,185	8,987,247	9,511,432	0.260668	54.00
60.00	06000	LABORATORY	950,045	8,347,223	9,297,268	0.265836	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	67,975	145,456	213,431	0.553771	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	1,386	327,218	328,604	0.304625	64.00
65.00	06500	RESPIRATORY THERAPY	258,718	1,253,478	1,512,196	0.366936	65.00
66.00	06600	PHYSICAL THERAPY	318,878	1,701,692	2,020,570	0.562258	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,459	223,717	340,176	0.305477	67.00
68.00	06800	SPEECH PATHOLOGY	20,630	171,367	191,997	0.352943	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	943,283	3,376,593	4,319,876	0.178872	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	222,867	181,920	404,787	0.696048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	661,589	1,883,401	2,544,990	0.380274	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	76.00
76.01	03951	CHEMOTHERAPY	3,861	2,930,152	2,934,013	0.698452	76.01
76.02	03020	WOUND CARE	1,313	99,424	100,737	0.552041	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	530,245	4,134,111	4,664,356	0.878072	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	88.01
90.00	09000	CLINIC	1,048	343,652	344,700	1.583487	90.00
91.00	09100	EMERGENCY	19,352	2,959,272	2,978,624	0.864144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	241,419	241,419	1.546191	92.00
200.00		Subtotal (see instructions)	6,852,317	39,243,007	46,095,324		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	6,852,317	39,243,007	46,095,324		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	CARDIAC REHAB	0.000000			76.00
76.01	03951	CHEMOTHERAPY	0.000000			76.01
76.02	03020	WOUND CARE	0.000000			76.02
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
90.00	09000	CLINIC	0.000000			90.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	217,808	2,220,010	0.098111	130,762	12,829	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,801	9,511,432	0.015855	242,713	3,848	54.00
60.00	06000	LABORATORY	105,623	9,297,268	0.011361	448,164	5,092	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,900	213,431	0.022958	33,554	770	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	2,057	328,604	0.006260	609	4	64.00
65.00	06500	RESPIRATORY THERAPY	41,666	1,512,196	0.027553	140,639	3,875	65.00
66.00	06600	PHYSICAL THERAPY	213,983	2,020,570	0.105902	59,643	6,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,652	340,176	0.004856	24,518	119	67.00
68.00	06800	SPEECH PATHOLOGY	1,050	191,997	0.005469	7,516	41	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,271	4,319,876	0.007007	457,092	3,203	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,421	404,787	0.025744	85,062	2,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,959	2,544,990	0.008628	278,884	2,406	73.00
76.00	03950	CARDIAC REHAB	0	0	0.000000	0	0	76.00
76.01	03951	CHEMOTHERAPY	93,564	2,934,013	0.031889	3,482	111	76.01
76.02	03020	WOUND CARE	2,744	100,737	0.027239	338	9	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	54,819	4,664,356	0.011753	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
90.00	09000	CLINIC	65,662	344,700	0.190490	1,048	200	90.00
91.00	09100	EMERGENCY	137,534	2,978,624	0.046174	1,313	61	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	23,945	241,419	0.099184	0	0	92.00
200.00		Total (lines 50 through 199)	1,180,459	44,169,186		1,915,337	41,074	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0 76.00
76.01	03951	CHEMOTHERAPY	0	0	0	0	0 76.01
76.02	03020	WOUND CARE	0	0	0	0	0 76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description		Title XVIII		Hospital		Cost	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,220,010	0.000000 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,511,432	0.000000 54.00
60.00	06000	LABORATORY	0	0	0	9,297,268	0.000000 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	213,431	0.000000 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000 62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	328,604	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,512,196	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,020,570	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	340,176	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	191,997	0.000000 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,319,876	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	404,787	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,544,990	0.000000 73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0.000000 76.00
76.01	03951	CHEMOTHERAPY	0	0	0	2,934,013	0.000000 76.01
76.02	03020	WOUND CARE	0	0	0	100,737	0.000000 76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,664,356	0.000000 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000 88.01
90.00	09000	CLINIC	0	0	0	344,700	0.000000 90.00
91.00	09100	EMERGENCY	0	0	0	2,978,624	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	241,419	0.000000 92.00
200.00		Total (lines 50 through 199)	0	0	0	44,169,186	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 9:01 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	130,762	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	242,713	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	448,164	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	33,554	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	609	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	140,639	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	59,643	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	24,518	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	7,516	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	457,092	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	85,062	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	278,884	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.000000	3,482	0	0	0	76.01
76.02	03020	WOUND CARE	0.000000	338	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	1,048	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	1,313	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,915,337	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 9:01 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	0.905132	0	760,347	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.260668	0	2,750,132	0	0	54.00
60.00	06000	LABORATORY	0.265836	0	2,926,783	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.553771	0	90,531	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.304625	0	174,948	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.366936	0	427,075	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.562258	0	548,603	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.305477	0	71,169	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.352943	0	45,297	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178872	0	1,265,674	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.696048	0	89,926	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380274	0	1,051,099	1,245	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.698452	0	1,586,060	1,935	0	76.01
76.02	03020	WOUND CARE	0.552041	0	65,553	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	1.583487	0	140,897	0	0	90.00
91.00	09100	EMERGENCY	0.864144	0	814,522	960	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.546191	0	100,952	0	0	92.00
200.00		Subtotal (see instructions)		0	12,909,568	4,140	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	12,909,568	4,140	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/25/2020 9:01 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	688,214	0				50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	716,871	0				54.00
60.00	06000	LABORATORY	778,044	0				60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	50,133	0				62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
64.00	06400	INTRAVENOUS THERAPY	53,294	0				64.00
65.00	06500	RESPIRATORY THERAPY	156,709	0				65.00
66.00	06600	PHYSICAL THERAPY	308,456	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	21,740	0				67.00
68.00	06800	SPEECH PATHOLOGY	15,987	0				68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	226,394	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62,593	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	399,706	473				73.00
76.00	03950	CARDIAC REHAB	0	0				76.00
76.01	03951	CHEMOTHERAPY	1,107,787	1,352				76.01
76.02	03020	WOUND CARE	36,188	0				76.02
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	223,109	0				90.00
91.00	09100	EMERGENCY	703,864	830				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	156,091	0				92.00
200.00		Subtotal (see instructions)	5,705,180	2,655				200.00
201.00		Less PBP Clinic Lab. Services-Program	0					201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)	5,705,180	2,655				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 9:01 am

			Title XIX		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	0.905132	0	25,508	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.260668	0	188,784	0	0	54.00
60.00	06000	LABORATORY	0.265836	0	103,436	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.553771	0	1,816	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.304625	0	1,635	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.366936	0	13,577	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.562258	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.305477	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.352943	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.178872	0	65,726	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.696048	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380274	0	20,910	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.01	03951	CHEMOTHERAPY	0.698452	0	0	0	0	76.01
76.02	03020	WOUND CARE	0.552041	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
88.01	08801	RURAL HEALTH CLINIC II						88.01
90.00	09000	CLINIC	1.583487	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.864144	0	97,917	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.546191	0	8,749	0	0	92.00
200.00		Subtotal (see instructions)		0	528,058	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	528,058	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/25/2020 9:01 am	
				Title XIX		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	23,088	0					50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,210	0					54.00
60.00	06000	LABORATORY	27,497	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,006	0					62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0					62.30
64.00	06400	INTRAVENOUS THERAPY	498	0					64.00
65.00	06500	RESPIRATORY THERAPY	4,982	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,757	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,952	0					73.00
76.00	03950	CARDIAC REHAB	0	0					76.00
76.01	03951	CHEMOTHERAPY	0	0					76.01
76.02	03020	WOUND CARE	0	0					76.02
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0					76.98
76.99	07699	LITHOTRIPSY	0	0					76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
88.01	08801	RURAL HEALTH CLINIC II							88.01
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	84,614	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,528	0					92.00
200.00		Subtotal (see instructions)	224,132	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	224,132	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 9:01 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)			2,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,524	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,337	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			281	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)			281	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			31	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)			31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			769	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)			165	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)			163	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			159.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.14	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,173,836	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			4,933	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)			4,933	25.00
26.00	Total swing-bed cost (see instructions)			1,131,702	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,042,134	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,042,134	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)			1,996.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,535,039	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)			1,535,039	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					667,247	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,202,286	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)					329,365	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					325,372	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					654,737	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)					187	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,996.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					373,280	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/25/2020 9:01 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	267,740	4,173,836	0.064147	373,280	23,945
91.00	Nursing School cost	0	4,173,836	0.000000	373,280	0
92.00	Allied health cost	0	4,173,836	0.000000	373,280	0
93.00	All other Medical Education	0	4,173,836	0.000000	373,280	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 9:01 am	
Cost Center Description		Title XIX	Hospital	Cost	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,524	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,337	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			281	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)			281	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			31	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)			31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			22	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			159.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.14	20.00
21.00	Total general inpatient routine service cost (see instructions)			4,173,836	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			4,933	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)			4,933	25.00
26.00	Total swing-bed cost (see instructions)			1,131,702	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,042,134	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,042,134	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)			1,996.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			43,915	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)			43,915	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1338

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

Worksheet D-1

Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					23,668	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					67,583	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					187	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,996.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					373,280	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1338		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 11/25/2020 9:01 am	
		Title XIX		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	267,740	4,173,836	0.064147	373,280	23,945	90.00
91.00	Nursing School cost	0	4,173,836	0.000000	373,280	0	91.00
92.00	Allied health cost	0	4,173,836	0.000000	373,280	0	92.00
93.00	All other Medical Education	0	4,173,836	0.000000	373,280	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/25/2020 9:01 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		801,420		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.905132	130,762	118,357	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.260668	242,713	63,268	54.00
60.00	06000 LABORATORY	0.265836	448,164	119,138	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.553771	33,554	18,581	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.304625	609	186	64.00
65.00	06500 RESPIRATORY THERAPY	0.366936	140,639	51,606	65.00
66.00	06600 PHYSICAL THERAPY	0.562258	59,643	33,535	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.305477	24,518	7,490	67.00
68.00	06800 SPEECH PATHOLOGY	0.352943	7,516	2,653	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.178872	457,092	81,761	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.696048	85,062	59,207	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.380274	278,884	106,052	73.00
76.00	03950 CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	0.698452	3,482	2,432	76.01
76.02	03020 WOUND CARE	0.552041	338	187	76.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	1.583487	1,048	1,659	90.00
91.00	09100 EMERGENCY	0.864144	1,313	1,135	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.546191	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,915,337	667,247	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,915,337		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1338 Component CCN: 14-Z338	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/25/2020 9:01 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.905132	9,461	8,563	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.260668	21,635	5,640	54.00
60.00	06000 LABORATORY	0.265836	86,674	23,041	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.553771	2,764	1,531	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.304625	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.366936	29,805	10,937	65.00
66.00	06600 PHYSICAL THERAPY	0.562258	121,524	68,328	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.305477	43,016	13,140	67.00
68.00	06800 SPEECH PATHOLOGY	0.352943	4,374	1,544	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.178872	60,519	10,825	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.696048	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.380274	61,339	23,326	73.00
76.00	03950 CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	0.698452	203	142	76.01
76.02	03020 WOUND CARE	0.552041	637	352	76.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	1.583487	0	0	90.00
91.00	09100 EMERGENCY	0.864144	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.546191	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		441,951	167,369	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		441,951		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/25/2020 9:01 am	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		22,807		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.905132	2,218	2,008	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.260668	8,754	2,282	54.00
60.00	06000 LABORATORY	0.265836	25,916	6,889	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.553771	912	505	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.304625	168	51	64.00
65.00	06500 RESPIRATORY THERAPY	0.366936	6,858	2,516	65.00
66.00	06600 PHYSICAL THERAPY	0.562258	294	165	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.305477	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.352943	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.178872	10,960	1,960	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.696048	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.380274	7,501	2,852	73.00
76.00	03950 CARDIAC REHAB	0.000000	0	0	76.00
76.01	03951 CHEMOTHERAPY	0.698452	0	0	76.01
76.02	03020 WOUND CARE	0.552041	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.878072	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000	0	0	88.01
90.00	09000 CLINIC	1.583487	0	0	90.00
91.00	09100 EMERGENCY	0.864144	5,138	4,440	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.546191	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		68,719	23,668	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		68,719		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/25/2020 9:01 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,707,835 1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)			0 2.00
3.00	OPPI 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)			5,707,835 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (see instructions)			5,764,913 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)			30,538 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,987,566 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)			3,746,809 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)			3,746,809 30.00
31.00	Primary payer payments			3,427 31.00
32.00	Subtotal (line 30 minus line 31)			3,743,382 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)			222,298 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			144,494 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			204,830 36.00
37.00	Subtotal (see instructions)			3,887,876 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			3,887,876 40.00
40.01	Sequestration adjustment (see instructions)			64,928 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0 40.03
41.00	Interim payments			3,616,345 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)			206,603 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: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/25/2020 9:01 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		2,316,401		3,618,572	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	01/15/2020	16,794		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	06/23/2020	199,298	01/15/2020	2,227	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)		-182,504		-2,227	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,133,897		3,616,345	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		206,603	6.01
6.02	SETTLEMENT TO PROGRAM		101,180		0	6.02
7.00	Total Medicare program liability (see instructions)		2,032,717		3,822,948	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: 14-1338

Period:

Worksheet E-1

Component CCN: 14-Z338

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
11/25/2020 9:01 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		884,240		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/23/2020	245,635		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	01/15/2020	10,529		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)		235,106		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,119,346		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		314,616		0	6.02
7.00	Total Medicare program liability (see instructions)		804,730		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: 14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 11/25/2020 9:01 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:14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2	
		Component CCN:14-Z338		Date/Time Prepared: 11/25/2020 9:01 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)		661,284	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)		169,043	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		328	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)		830,327	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		830,327	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)		830,327	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		11,930	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		818,397	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)		818,397	0	19.00
19.01	Sequestration adjustment (see instructions)		13,667	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,119,346	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)		-314,616	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:14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 11/25/2020 9:01 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,202,286	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)		2,202,286	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,224,309	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)		2,224,309	19.00
20.00	Deductibles (exclude professional component)		181,500	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,042,809	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,042,809	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		37,586	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		24,431	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		36,222	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,067,240	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)		2,067,240	30.00
30.01	Sequestration adjustment (see instructions)		34,523	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,133,897	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)		-101,180	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1338	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2020 9:01 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		67,583		1.00
2.00	Medical and other services			224,132	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		67,583	224,132	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		67,583	224,132	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		48,225		8.00
9.00	Ancillary service charges		68,719	528,058	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		116,944	528,058	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		116,944	528,058	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		49,361	303,926	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		67,583	224,132	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		67,583	224,132	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		67,583	224,132	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		67,583	224,132	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		67,583	224,132	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		67,583	224,132	40.00
41.00	Interim payments		67,583	224,132	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1338

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

Worksheet G

Date/Time Prepared:
11/25/2020 9:01 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	8,620,640	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,996,262	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,454,262	0	0	0	6.00
7.00	Inventory	400,493	0	0	0	7.00
8.00	Prepaid expenses	0	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)	13,563,133	0	0	0	11.00
FIXED ASSETS						
12.00	Land	232,983	0	0	0	12.00
13.00	Land improvements	699,764	0	0	0	13.00
14.00	Accumulated depreciation	-576,405	0	0	0	14.00
15.00	Buildings	20,818,865	0	0	0	15.00
16.00	Accumulated depreciation	-10,143,003	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	1,000,778	0	0	0	19.00
20.00	Accumulated depreciation	-880,295	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	12,150,540	0	0	0	23.00
24.00	Accumulated depreciation	-11,066,863	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	1,687,027	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)	13,923,391	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	33,795,716	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,795,716	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	61,282,240	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,203,967	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	7,442,370	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,646,337	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,646,337	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	52,635,903	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	52,635,903	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	61,282,240	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1338

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

Worksheet G-1

Date/Time Prepared:
11/25/2020 9:01 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		49,292,051		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,343,852				2.00
3.00	Total (sum of line 1 and line 2)		52,635,903		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)		52,635,903		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		52,635,903		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1338

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2020 9:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,344,956		1,344,956	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	471,739		471,739	5.00
6.00	Swing bed - NF	52,042		52,042	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)	1,868,737		1,868,737	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)	1,868,737		1,868,737	17.00
18.00	Ancillary services	4,393,669		4,393,669	18.00
19.00	Outpatient services	0	32,960,006	32,960,006	19.00
20.00	RURAL HEALTH CLINIC	530,245	6,346,806	6,877,051	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	7,673	3,381,248	3,388,921	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,800,324	42,688,060	49,488,384	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,829,476		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,829,476		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1338

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

Worksheet G-3

Date/Time Prepared:
11/25/2020 9:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	49,488,384	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,151,297	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,337,087	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,829,476	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-492,389	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	721,852	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	120,391	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	49,045	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	65,419	17.00
18.00	Revenue from sale of medical records and abstracts	14,301	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	340B RETAILPHARMACY NET REV	2,003,598	24.00
24.01	OTHER OPER REV - BUSI UNIT 5000	636,056	24.01
24.02	OTHER NON OP REV	225,579	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,836,241	25.00
26.00	Total (line 5 plus line 25)	3,343,852	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,343,852	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1338

Period:

Worksheet M-1

Component CCN: 14-8543

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/25/2020 9:01 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	1,380,673	279,243	1,659,916	-134,515	1,525,401
2.00	Physician Assistant	162,352	30,554	192,906	-9	192,897
3.00	Nurse Practitioner	123,415	23,226	146,641	0	146,641
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	459,490	86,474	545,964	0	545,964
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	148,316	27,913	176,229	0	176,229
9.00	Other Facility Health Care Staff Costs	215,429	40,543	255,972	0	255,972
10.00	Subtotal (sum of lines 1 through 9)	2,489,675	487,953	2,977,628	-134,524	2,843,104
11.00	Physician Services Under Agreement	0	987,894	987,894	0	987,894
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	987,894	987,894	0	987,894
15.00	Medical Supplies	0	18,648	18,648	0	18,648
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	49,969	49,969	-49,969	0
19.00	Other Health Care Costs	0	339,243	339,243	-52,163	287,080
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	407,860	407,860	-102,132	305,728
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,489,675	1,883,707	4,373,382	-236,656	4,136,726
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	1,134	1,134
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	1,134	1,134
FACILITY OVERHEAD						
29.00	Facility Costs	0	156,831	156,831	0	156,831
30.00	Administrative Costs	458,531	190,740	649,271	-464,505	184,766
31.00	Total Facility Overhead (sum of lines 29 and 30)	458,531	347,571	806,102	-464,505	341,597
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,948,206	2,231,278	5,179,484	-700,027	4,479,457

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1338

Period:

Worksheet M-1

Component CCN: 14-8543

From 07/01/2019
To 06/30/2020Date/Time Prepared:
11/25/2020 9:01 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,525,401	1.00
2.00	Physician Assistant	0	192,897	2.00
3.00	Nurse Practitioner	0	146,641	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	545,964	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	176,229	8.00
9.00	Other Facility Health Care Staff Costs	0	255,972	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,843,104	10.00
11.00	Physician Services Under Agreement	-987,894	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	-987,894	0	14.00
15.00	Medical Supplies	0	18,648	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	-77,749	209,331	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	-77,749	227,979	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-1,065,643	3,071,083	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	1,134	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	1,134	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	156,831	29.00
30.00	Administrative Costs	-1,500	183,266	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,500	340,097	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,067,143	3,412,314	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1338 Component CCN: 14-8543		Period: From 07/01/2019 To 06/30/2020		Worksheet M-2 Date/Time Prepared: 11/25/2020 9:01 am	
			RHC I		Cost			
			Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
			1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician		3.74	14,472	4,200	15,708		1.00
2.00	Physician Assistant		1.21	3,012	2,100	2,541		2.00
3.00	Nurse Practitioner		0.93	2,404	2,100	1,953		3.00
4.00	Subtotal (sum of lines 1 through 3)		5.88	19,888		20,202	20,202	4.00
5.00	Visiting Nurse		0.00	0			0	5.00
6.00	Clinical Psychologist		0.00	0			0	6.00
7.00	Clinical Social Worker		0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)		0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)		0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)		5.88	19,888			20,202	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)						3,071,083	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						1,134	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						3,072,217	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						0.999631	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						340,097	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						683,325	15.00
16.00	Total overhead (sum of lines 14 and 15)						1,023,422	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						1,023,422	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						1,023,044	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						4,094,127	20.00

Health Financial Systems		MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1338	Period: From 07/01/2019	Worksheet M-3	
		Component CCN:14-8543	To 06/30/2020	Date/Time Prepared: 11/25/2020 9:01 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)			4,094,127	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			122,011	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,972,116	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,202	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			20,202	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			196.62	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)		196.62	196.62	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		3,301	2,496	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		649,043	490,764	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,139,807	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,095,931	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,809	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,921	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.)			844,402	16.04
16.05	Total program cost (see instructions)		0	847,323	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			81,383	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			202,260	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			847,323	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			36,135	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			883,458	22.00
23.00	Allowable bad debts (see instructions)			43,974	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			28,583	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			38,046	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)			912,041	26.00
26.01	Sequestration adjustment (see instructions)			15,231	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			759,078	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)			137,732	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: 14-1338 Component CCN: 14-8543	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/25/2020 9:01 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)		2,843,104	2,843,104	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001416	0.007498	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		4,026	21,318	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		28,690	37,489	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		32,716	58,807	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,071,083	3,071,083	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,023,044	1,023,044	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010653	0.019149	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		10,898	19,590	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		43,614	78,397	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		275	1,456	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		158.60	53.84	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		71	462	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		11,261	24,874	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)			122,011	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)			36,135	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1338 Component CCN: 14-8543	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/25/2020 9:01 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		601,210	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01		01/15/2020	4,191	3.01	
3.02		01/15/2020	9,954	3.02	
3.03		06/23/2020	42,080	3.03	
3.04		06/23/2020	101,643	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)		157,868	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		759,078	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		137,732	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		896,810	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00