

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

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 6/23/2021 3:28 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 6/23/2021	Time: 3:28 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PANA COMMUNITY HOSPITAL (14-1341) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) JAMES MOON

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	192,355	-350,491	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	142,550	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		82,454		0	10.00
200.00	Total	0	334,905	-268,037	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: 14-1341		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 6/23/2021 3:28 pm		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 101 E. 9TH STREET			PO Box:				1.00			
2.00	City: PANA			State: IL		Zip Code: 62557-1716		County: CHRISTIAN			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		PANA COMMUNITY HOSPITAL	141341	99914	1	11/01/2004	N	O	N	
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF		PANA COMMUNITY HOSPITAL	142341	99914		04/06/2004	N	O	N	
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTG										
12.00	Hospital-Based HHA		QUAD COUNTY HOME HEALTH AGENCY	147299	99914		01/01/1985	N	P	N	
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice		PCH HOSPICE	141575	99914		08/31/1994				
15.00	Hospital-Based Health Clinic - RHC		COMMUNITY MEDICAL CLINIC PANA	148508	99914		03/18/2010	N	O	N	
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2020		12/31/2020		20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
					1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 01/01/2020
To 12/31/2020Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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To 12/31/2020Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 6/23/2021 3:28 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Prepared: 6/23/2021 3:28 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	121,536	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1341		Period: From 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 6/23/2021 3:28 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							N	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)							Y	168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 6/23/2021 3:28 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/12/2021	Y	03/12/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet S-2
Part II
Date/Time Prepared:
6/23/2021 3:28 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.		Y		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.		Y		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.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4300	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet 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.	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: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,052	17,136.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,052	17,136.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		22	8,052	17,136.00	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	521	0	724			1.00
2.00	HMO and other (see instructions)	102	55				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	363	0	433			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	28			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	884	0	1,185			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)	884	0	1,185	0.00	152.58	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	6,216	0	9,582	0.00	16.29	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	6.72	24.00
24.10	HOSPICE (non-distinct part)			8			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	2,321	0	11,227	0.00	22.74	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	198.33	27.00
28.00	Observation Bed Days		0	64			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: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	177	0	249	1.00
2.00 HMO and other (see instructions)			31	22		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	177	0	249	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					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

HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-1341 Component CCN: 14-7299		Period: From 01/01/2020 To 12/31/2020		Worksheet S-4 Date/Time Prepared: 6/23/2021 3:28 pm	
						Home Health Agency I		PPS	
						1.00			
0.00	County					CHRISTIAN			0.00
				Title V	Title XVIII	Title XIX	Other	Total	
				1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA								
1.00	Home Health Aide Hours		0	348	52	65	465	1.00	
2.00	Unduplicated Census Count (see instructions)		0.00	427.00	64.00	79.00	570.00	2.00	
			Enter the number of hours in your normal work week		Number of Employees (Full Time Equivalent)				
					Staff	Contract	Total		
			0		1.00	2.00	3.00		
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)		40.00		1.93	0.00	1.93	3.00	
4.00	Director(s) and Assistant Director(s)				0.00	0.00	0.00	4.00	
5.00	Other Administrative Personnel				0.00	0.00	0.00	5.00	
6.00	Direct Nursing Service				11.63	0.00	11.63	6.00	
7.00	Nursing Supervisor				0.00	0.00	0.00	7.00	
8.00	Physical Therapy Service				1.43	0.28	1.71	8.00	
9.00	Physical Therapy Supervisor				0.00	0.00	0.00	9.00	
10.00	Occupational Therapy Service				0.74	0.17	0.91	10.00	
11.00	Occupational Therapy Supervisor				0.00	0.00	0.00	11.00	
12.00	Speech Pathology Service				0.31	0.01	0.32	12.00	
13.00	Speech Pathology Supervisor				0.00	0.00	0.00	13.00	
14.00	Medical Social Service				0.03	0.00	0.03	14.00	
15.00	Medical Social Service Supervisor				0.00	0.00	0.00	15.00	
16.00	Home Health Aide				0.22	0.00	0.22	16.00	
17.00	Home Health Aide Supervisor				0.00	0.00	0.00	17.00	
18.00	Other (specify)				0.00	0.00	0.00	18.00	
	HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				2			19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				99914			20.00	
20.01					41180			20.01	
			Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
			Without Outliers	With Outliers					
			1.00	2.00					3.00
	PPS ACTIVITY DATA								
21.00	Skilled Nursing Visits		430	1,960	38	15	2,443	21.00	
22.00	Skilled Nursing Visit Charges		90,250	413,900	8,450	3,165	515,765	22.00	
23.00	Physical Therapy Visits		607	2,001	28	2	2,638	23.00	
24.00	Physical Therapy Visit Charges		136,575	448,440	6,300	440	591,755	24.00	
25.00	Occupational Therapy Visits		390	595	3	1	989	25.00	
26.00	Occupational Therapy Visit Charges		94,380	142,857	726	242	238,205	26.00	
27.00	Speech Pathology Visits		82	51	0	0	133	27.00	
28.00	Speech Pathology Visit Charges		19,844	12,298	0	0	32,142	28.00	
29.00	Medical Social Service Visits		3	6	0	0	9	29.00	
30.00	Medical Social Service Visit Charges		840	1,667	0	0	2,507	30.00	
31.00	Home Health Aide Visits		4	0	0	0	4	31.00	
32.00	Home Health Aide Visit Charges		540	0	0	0	540	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)		1,516	4,613	69	18	6,216	33.00	
34.00	Other Charges		0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)		342,429	1,019,162	15,476	3,847	1,380,914	35.00	
36.00	Total Number of Episodes (standard/non outlier)		420		39	4	463	36.00	
37.00	Total Number of Outlier Episodes			58		0	58	37.00	
38.00	Total Non-Routine Medical Supply Charges		2,046	9,850	272	26	12,194	38.00	

Health Financial Systems		PANA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1341 Component CCN: 14-8508		Period: From 01/01/2020 To 12/31/2020 Worksheet S-8 Date/Time Prepared: 6/23/2021 3:28 pm	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	101 E. 9TH STREET, SUITE 105		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	PANA IL		62557	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:30		20:00	08:30
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	Y		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		3	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number	COMMUNITY MEDICAL CLINIC		148508	14.00
14.01		PANA COMMUNITY MEDICAL CLINIC OF ASSUMPTI		148575	14.01
14.02		COMMUNITY MEDICAL CLINIC OF NOKOMIS		148574	14.02
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County			
		4.00			
2.00	City, State, ZIP Code, County	CHRISTIAN		2.00	

Worksheet S-8
Date/Time Prepared:
6/23/2021 3:28 pm

MCRIF32 - 16.10.172.0

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-1341

Period:

Worksheet S-9

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020PARTS I THROUGH IV
Date/Time Prepared:
6/23/2021 3:28 pm

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	5,907	304	380	6,591	11.00
12.00	Hospice Inpatient Respite Care	8	0	0	8	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	5,915	304	380	6,599	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet S-10

Date/Time Prepared:
6/23/2021 3:28 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.482081	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,692,947	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		2,257,831	5.00
6.00	Medicaid charges		8,459,396	6.00
7.00	Medicaid cost (line 1 times line 6)		4,078,114	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)		127,336	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		10,833	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		127,336	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,638	9,730	13,368
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,754	9,730	11,484
22.00	Payments received from patients for amounts previously written off as charity care	1,819	4,865	6,684
23.00	Cost of charity care (line 21 minus line 22)	0	4,865	4,865
			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)		1,491,215	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		231,321	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		355,879	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,135,336	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		671,882	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		676,747	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		804,083	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES					Provider CCN: 14-1341		Period: From 01/01/2020 To 12/31/2020		Worksheet A Date/Time Prepared: 6/23/2021 3:28 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)			
			1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,506,653	1,506,653	-802,898	703,755	1.00		
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX		247,691	247,691	853,350	1,101,041	1.01		
2.00	00200	CAP REL COSTS-MVBLE EQUIP		571,450	571,450	13,961	585,411	2.00		
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,137,413	3,137,413	-72	3,137,341	4.00		
5.01	00540	NONPATIENT TELEPHONES	0	0	0	158,088	158,088	5.01		
5.02	00550	DATA PROCESSING	345,971	292,366	638,337	-123,768	514,569	5.02		
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	419,114	431,293	850,407	-34,209	816,198	5.03		
5.04	00590	OTHER ADMIN AND GENERAL	863,269	1,387,921	2,251,190	-9,786	2,241,404	5.04		
7.00	00700	OPERATION OF PLANT	238,496	480,265	718,761	0	718,761	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	43,361	43,361	8.00		
9.00	00900	HOUSEKEEPING	314,381	77,339	391,720	-43,361	348,359	9.00		
10.00	01000	DIETARY	236,808	255,064	491,872	-439,908	51,964	10.00		
11.00	01100	CAFETERIA	0	0	0	241,493	241,493	11.00		
13.00	01300	NURSING ADMINISTRATION	234,153	8,451	242,604	0	242,604	13.00		
14.00	01400	CENTRAL SERVICES & SUPPLY	40,538	41,942	82,480	0	82,480	14.00		
15.00	01500	PHARMACY	232,540	894,792	1,127,332	-773,770	353,562	15.00		
16.00	01600	MEDICAL RECORDS & LIBRARY	160,101	51,596	211,697	0	211,697	16.00		
17.00	01700	SOCIAL SERVICE	117,451	8,572	126,023	0	126,023	17.00		
19.00	01900	NONPHYSICIAN ANESTHETISTS	947	0	947	246,648	247,595	19.00		
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	986,517	124,029	1,110,546	0	1,110,546	30.00		
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	286,100	497,254	783,354	0	783,354	50.00		
53.00	05300	ANESTHESIOLOGY	0	257,663	257,663	-246,576	11,087	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	470,294	804,391	1,274,685	0	1,274,685	54.00		
60.00	06000	LABORATORY	617,239	496,672	1,113,911	0	1,113,911	60.00		
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00		
65.00	06500	RESPIRATORY THERAPY	511,799	156,940	668,739	0	668,739	65.00		
66.00	06600	PHYSICAL THERAPY	529,645	63,554	593,199	0	593,199	66.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,290	32,290	0	32,290	71.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	773,770	773,770	73.00		
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	1,729,243	575,158	2,304,401	948	2,305,349	88.00		
91.00	09100	EMERGENCY	1,032,894	1,985,061	3,017,955	0	3,017,955	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00		
OTHER REIMBURSABLE COST CENTERS										
101.00	10100	HOME HEALTH AGENCY	951,953	328,151	1,280,104	0	1,280,104	101.00		
SPECIAL PURPOSE COST CENTERS										
116.00	11600	HOSPICE	354,055	209,153	563,208	0	563,208	116.00		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,673,508	14,923,124	25,596,632	-142,729	25,453,903	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	1,267,726	541,239	1,808,965	-111	1,808,854	192.00		
194.00	07950	HOMEBOUND MEALS	0	0	0	142,840	142,840	194.00		
194.01	07951	FITNESS WELLNESS PROGRAM	100,888	13,931	114,819	0	114,819	194.01		
194.02	07952	FOUNDATION	47,438	3,193	50,631	0	50,631	194.02		
200.00		TOTAL (SUM OF LINES 118 through 199)	12,089,560	15,481,487	27,571,047	0	27,571,047	200.00		

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	703,755	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	-158,585	942,456	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-45	585,366	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-444,102	2,693,239	4.00
5.01	00540	NONPATIENT TELEPHONES	-6,266	151,822	5.01
5.02	00550	DATA PROCESSING	0	514,569	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	816,198	5.03
5.04	00590	OTHER ADMIN AND GENERAL	-624,203	1,617,201	5.04
7.00	00700	OPERATION OF PLANT	-13,503	705,258	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,361	8.00
9.00	00900	HOUSEKEEPING	0	348,359	9.00
10.00	01000	DIETARY	-486	51,478	10.00
11.00	01100	CAFETERIA	-43,888	197,605	11.00
13.00	01300	NURSING ADMINISTRATION	0	242,604	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	82,480	14.00
15.00	01500	PHARMACY	-47,756	305,806	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,839	185,858	16.00
17.00	01700	SOCIAL SERVICE	0	126,023	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	247,595	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-273,198	837,348	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-120,915	662,439	50.00
53.00	05300	ANESTHESIOLOGY	0	11,087	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,274,685	54.00
60.00	06000	LABORATORY	-2,457	1,111,454	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-41,040	627,699	65.00
66.00	06600	PHYSICAL THERAPY	-1,750	591,449	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,290	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	773,770	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,305,349	88.00
91.00	09100	EMERGENCY	-1,009,304	2,008,651	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,280,104	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	1,258	564,466	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,812,079	22,641,824	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,808,854	192.00
194.00	07950	HOMEBOUND MEALS	0	142,840	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	114,819	194.01
194.02	07952	FOUNDATION	0	50,631	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,812,079	24,758,968	200.00

RECLASSIFICATIONS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
6/23/2021 3:28 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - DIETARY COSTS					
1.00	CAFETERIA	11.00	116,265	125,228	1.00
2.00	OTHER ADMIN AND GENERAL	5.04	26,756	28,819	2.00
3.00	HOMEBOUND MEALS	194.00	68,769	74,071	3.00
	0		211,790	228,118	
B - CRNAS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	72	1.00
2.00	NONPHYSICIAN ANESTHETISTS	19.00	0	246,576	2.00
	0		0	246,648	
C - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	64,413	1.00
	0		0	64,413	
D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	43,361	1.00
	0		0	43,361	
E - TELEPHONE AND POSTAGE					
1.00	NONPATIENT TELEPHONES	5.01	34,320	123,768	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	0	111	2.00
3.00		0.00	0	0	3.00
	0		34,320	123,879	
G - RHC PHYSICIAN RECRUITMENT					
1.00	RURAL HEALTH CLINIC	88.00	0	948	1.00
	0		0	948	
I - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT NEW BDG EX	1.01	0	828,646	1.00
	TOTALS		0	828,646	
J - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	773,770	1.00
	TOTALS		0	773,770	
500.00	Grand Total: Increases		246,110	2,309,783	500.00

RECLASSIFICATIONS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
6/23/2021 3:28 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - DIETARY COSTS						
1.00	DIETARY	10.00	211,790	228,118	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		211,790	228,118		
B - CRNAS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	72	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	246,576	0	2.00
	0		0	246,648		
C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.04	0	64,413	12	1.00
	0		0	64,413		
D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	43,361	0	1.00
	0		0	43,361		
E - TELEPHONE AND POSTAGE						
1.00	DATA PROCESSING	5.02	0	123,768	0	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	34,320	0	0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	111	0	3.00
	0		34,320	123,879		
G - RHC PHYSICIAN RECRUITMENT						
1.00	OTHER ADMIN AND GENERAL	5.04	0	948	0	1.00
	0		0	948		
I - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	828,646	12	1.00
	TOTALS		0	828,646		
J - DRUG COSTS						
1.00	PHARMACY	15.00	0	773,770	0	1.00
	TOTALS		0	773,770		
500.00	Grand Total: Decreases		246,110	2,309,783		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
6/23/2021 3:28 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	51,361	0	0	0	0	1.00	
2.00	Land Improvements	2,386,658	631,119	0	631,119	0	2.00	
3.00	Buildings and Fixtures	25,551,686	3,705,128	0	3,705,128	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	882,707	40,481	0	40,481	0	5.00	
6.00	Movable Equipment	8,526,099	721,043	0	721,043	46,852	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	37,398,511	5,097,771	0	5,097,771	46,852	8.00	
9.00	Reconciling Items	-3,722,868	3,715,923	0	3,715,923	0	9.00	
10.00	Total (line 8 minus line 9)	41,121,379	1,381,848	0	1,381,848	46,852	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	51,361	0				1.00	
2.00	Land Improvements	3,017,777	0				2.00	
3.00	Buildings and Fixtures	29,256,814	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	923,188	0				5.00	
6.00	Movable Equipment	9,200,290	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	42,449,430	0				8.00	
9.00	Reconciling Items	-6,945	0				9.00	
10.00	Total (line 8 minus line 9)	42,456,375	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,506,653	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	0	247,691	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	571,450	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,078,103	0	247,691	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,506,653				1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	247,691				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	571,450				2.00
3.00	Total (sum of lines 1-2)	0	2,325,794				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	16,968,731	0	16,968,731	0.399740	25,748	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	16,280,409	0	16,280,409	0.383525	24,704	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	9,200,290	0	9,200,290	0.216735	13,961	2.00	
3.00	Total (sum of lines 1-2)	42,449,430	0	42,449,430	1.000000	64,413	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	25,748	1,506,653	0	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	0	24,704	0	0	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,961	571,405	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	64,413	2,078,058	0	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	-802,898	0	0	703,755	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	89,106	853,350	0	0	942,456	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,961	0	0	585,366	2.00	
3.00	Total (sum of lines 1-2)	89,106	64,413	0	0	2,231,577	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT NEW BDG EX (chapter 2)	B	-158,585	CAP REL COSTS-BLDG & FIXT NEW BDG EX	1.01	11	1.01
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)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-13,503	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,445,656			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-43,888	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-25,839	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines	B	-486	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		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
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT NEW BDG EX			0CAP REL COSTS-BLDG & FIXT NEW BDG EX	1.01	0	26.01
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		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	A	-1,258	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
6/23/2021 3:28 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MISCELLANEOUS INCOME	B	-14,089	OTHER ADMIN AND GENERAL	5.04	0	33.00
34.00 SPORTS MEDICINE INCOME	B	-1,750	PHYSICAL THERAPY	66.00	0	34.00
35.00 ADVERTISING	A	-55,315	OTHER ADMIN AND GENERAL	5.04	0	35.00
36.00 PATIENT PHONE COSTS - CAPITAL	A	-45	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01 PATIENT PHONE COSTS - BENEFITS	A	-508	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
36.02 PATIENT PHONE COSTS - SALARY	A	-2,235	NONPATIENT TELEPHONES	5.01	0	36.02
36.03 PATIENT PHONE COSTS - OTHER	A	-4,031	NONPATIENT TELEPHONES	5.01	0	36.03
38.00 SELF-INS CASH PMNTS TO HOSPITAL	A	-389,972	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00 PHYSICIAN RECRUITMENT	A	-750	OTHER ADMIN AND GENERAL	5.04	0	39.00
40.00 HOSPICE COSTS	A	1,258	HOSPICE	116.00	0	40.00
41.00 LOBBYING	A	-10,250	OTHER ADMIN AND GENERAL	5.04	0	41.00
44.00 MEDICAID TAX	A	-524,331	OTHER ADMIN AND GENERAL	5.04	0	44.00
45.00 GOODWILL AMORTIZATION	A	-19,468	OTHER ADMIN AND GENERAL	5.04	0	45.00
45.01 PHYSICIAN BENEFITS	A	-53,622	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02 340B RETAIL PHARMACY COSTS	A	-47,756	PHARMACY	15.00	0	45.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,812,079				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: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
6/23/2021 3:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	27,000	2,457	24,543	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	41,040	41,040	0	0	0	2.00
3.00	91.00	EMERGENCY	1,828,174	1,009,304	818,870	0	0	3.00
4.00	50.00	OPERATING ROOM	120,915	120,915	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	271,940	271,940	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,289,069	1,445,656	843,413		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	2,457		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	41,040		2.00
3.00	91.00	EMERGENCY	0	0	0	1,009,304		3.00
4.00	50.00	OPERATING ROOM	0	0	0	120,915		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	271,940		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,445,656		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1341		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/23/2021 3:28 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					1	1.00
2.00	Line 1 multiplied by 15 hours per week					15	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					1	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					5.75	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	1.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	43.54	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)	21.77	21.77	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					44	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)					44	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)					44	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)					44.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					660	22.00
23.00	Total salary equivalency (see instructions)					660	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)					22	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)					22	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)					6	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					28	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)					28	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: 14-1341		Period: From 01/01/2020 To 12/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/23/2021 3:28 pm	
				Speech Pathology		Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	43.54	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					660	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					28	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)					688	63.00
64.00	Total cost of outside supplier services (from your records)					224	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					22	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					6	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					28	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					6	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					6	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: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	BLDG & FIXT NEW BDG EX	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	703,755	703,755			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	942,456	0	942,456		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	585,366		585,366		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,693,239	0	0	2,693,239	4.00
5.01	00540	NONPATIENT TELEPHONES	151,822	880	0	7,718	5.01
5.02	00550	DATA PROCESSING	514,569	15,915	4,566	33,429	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	816,198	24,246	0	3,971	5.03
5.04	00590	OTHER ADMIN AND GENERAL	1,617,201	80,889	51,069	6,746	5.04
7.00	00700	OPERATION OF PLANT	705,258	224,973	338,764	2,620	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,361	0	0	0	8.00
9.00	00900	HOUSEKEEPING	348,359	10,388	2,720	1,901	9.00
10.00	01000	DIETARY	51,478	10,865	55,602	8,224	10.00
11.00	01100	CAFETERIA	197,605	0	34,067	0	11.00
13.00	01300	NURSING ADMINISTRATION	242,604	1,834	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	82,480	872	32,513	0	14.00
15.00	01500	PHARMACY	305,806	5,313	0	6,980	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	185,858	5,042	0	1,777	16.00
17.00	01700	SOCIAL SERVICE	126,023	1,768	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	247,595	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	837,348	54,916	0	6,147	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	662,439	0	289,120	148,325	50.00
53.00	05300	ANESTHESIOLOGY	11,087	0	0	12,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,274,685	15,923	53,983	252,274	54.00
60.00	06000	LABORATORY	1,111,454	2,920	51,846	49,178	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	627,699	21,228	28,206	18,405	65.00
66.00	06600	PHYSICAL THERAPY	591,449	76,374	0	14,068	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,290	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	773,770	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,305,349	27,890	0	4,396	88.00
91.00	09100	EMERGENCY	2,008,651	31,928	0	10,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,280,104	32,109	0	2,088	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	564,466	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,641,824	646,273	942,456	582,638	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,035	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,808,854	52,555	0	971	192.00
194.00	07950	HOMEBOUND MEALS	142,840	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	114,819	0	0	1,757	194.01
194.02	07952	FOUNDATION	50,631	1,892	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,758,968	703,755	942,456	585,366	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.01	5.02	5.03	5A.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	160,420					5.01
5.02	00550	DATA PROCESSING	21,511	668,967				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	11,063	41,440	984,757			5.03
5.04	00590	OTHER ADMIN AND GENERAL	6,761	26,640	0	1,992,477	1,992,477	5.04
7.00	00700	OPERATION OF PLANT	1,844	5,920	0	1,333,822	116,733	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	43,361	3,795	8.00
9.00	00900	HOUSEKEEPING	1,229	2,960	0	439,323	38,449	9.00
10.00	01000	DIETARY	2,459	11,840	0	146,179	12,793	10.00
11.00	01100	CAFETERIA	0	0	0	258,213	22,598	11.00
13.00	01300	NURSING ADMINISTRATION	1,844	8,880	0	308,614	27,009	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	615	2,960	0	128,694	11,263	14.00
15.00	01500	PHARMACY	2,459	11,840	0	385,481	33,737	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,688	11,840	0	244,752	21,420	16.00
17.00	01700	SOCIAL SERVICE	1,229	5,920	0	161,751	14,156	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	247,595	21,669	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,137	20,720	41,662	1,138,051	99,600	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,917	23,680	64,288	1,253,970	109,745	50.00
53.00	05300	ANESTHESIOLOGY	615	2,960	17,849	44,606	3,904	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,146	29,600	289,300	2,029,268	177,597	54.00
60.00	06000	LABORATORY	6,146	29,600	230,078	1,622,123	141,965	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,990	23,680	62,258	906,297	79,317	65.00
66.00	06600	PHYSICAL THERAPY	8,605	38,480	54,142	904,023	79,118	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,995	35,285	3,088	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	96,506	870,276	76,165	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	20,898	97,681	0	2,850,961	249,512	88.00
91.00	09100	EMERGENCY	9,834	23,680	125,679	2,445,571	214,031	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	9,220	38,480	0	1,579,309	138,218	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	109,525	0	754,813	66,060	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,210	568,326	984,757	22,124,815	1,761,942	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	615	0	0	3,650	319	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,751	85,841	0	2,252,363	197,122	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	158,538	13,875	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,229	11,840	0	152,675	13,362	194.01
194.02	07952	FOUNDATION	615	2,960	0	66,927	5,857	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	160,420	668,967	984,757	24,758,968	1,992,477	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	1,450,555					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,156				8.00
9.00	00900	HOUSEKEEPING	31,388	0	509,160			9.00
10.00	01000	DIETARY	70,792	0	25,661	255,425		10.00
11.00	01100	CAFETERIA	24,514	0	8,886	0	314,211	11.00
13.00	01300	NURSING ADMINISTRATION	5,196	0	1,884	0	5,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,865	0	9,376	0	3,227	14.00
15.00	01500	PHARMACY	15,053	0	5,457	0	5,674	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,284	0	5,178	0	7,705	16.00
17.00	01700	SOCIAL SERVICE	5,010	0	1,816	0	5,153	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	155,588	17,326	56,399	255,425	28,345	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	208,041	3,436	75,412	0	10,385	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	83,957	4,972	30,434	0	20,900	54.00
60.00	06000	LABORATORY	45,579	0	16,522	0	25,378	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	80,439	387	29,158	0	22,098	65.00
66.00	06600	PHYSICAL THERAPY	216,385	5,431	78,434	0	19,521	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	124,177	0	45,013	0	48,544	88.00
91.00	09100	EMERGENCY	90,459	15,604	32,790	0	41,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	90,971	0	27,705	0	7,365	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	2,603	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,287,698	47,156	450,125	255,425	253,905	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	8,598	0	3,117	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	148,900	0	53,975	0	51,405	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	0	0	6,324	194.01
194.02	07952	FOUNDATION	5,359	0	1,943	0	2,577	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,450,555	47,156	509,160	255,425	314,211	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMIN AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	348,195				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	178,425			14.00
15.00	01500	PHARMACY	11,039	236	456,677		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,201	0	294,540	16.00
17.00	01700	SOCIAL SERVICE	10,026	20	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	55,146	36,774	0	11,684	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,205	30,207	0	18,030	50.00
53.00	05300	ANESTHESIOLOGY	0	5,290	0	5,006	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,663	6,375	0	81,126	54.00
60.00	06000	LABORATORY	49,374	5,550	0	64,526	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	42,993	5,415	0	17,460	65.00
66.00	06600	PHYSICAL THERAPY	37,980	2,424	0	15,184	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25	0	840	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	456,677	27,065	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	12,749	0	0	88.00
91.00	09100	EMERGENCY	80,769	54,965	0	35,247	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	10,219	0	11,282	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	292	0	7,090	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	348,195	171,742	456,677	294,540	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,995	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	639	0	0	194.01
194.02	07952	FOUNDATION	0	49	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	348,195	178,425	456,677	294,540	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMIN AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
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	269,264				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,012,684	-66,542	1,946,142	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,729,431	0	1,729,431	50.00
53.00	05300	ANESTHESIOLOGY	269,264	328,070	0	328,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,475,292	0	2,475,292	54.00
60.00	06000	LABORATORY	0	1,971,017	1,789	1,972,806	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64,753	64,753	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,183,564	0	1,183,564	65.00
66.00	06600	PHYSICAL THERAPY	0	1,358,500	0	1,358,500	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,238	0	39,238	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,430,183	0	1,430,183	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,330,956	0	3,330,956	88.00
91.00	09100	EMERGENCY	0	3,050,537	0	3,050,537	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,865,069	0	1,865,069	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE		830,858	0	830,858	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269,264	21,605,399	0	21,605,399	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	15,684	0	15,684	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,709,760	0	2,709,760	192.00
194.00	07950	HOMEBOUND MEALS	0	172,413	0	172,413	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	173,000	0	173,000	194.01
194.02	07952	FOUNDATION	0	82,712	0	82,712	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	269,264	24,758,968	0	24,758,968	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1341

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	BLDG & FIXT NEW BDG EX	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	880	0	880	5.01
5.02	00550	DATA PROCESSING	0	15,915	4,566	33,429	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,103	24,246	0	3,971	5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	80,889	51,069	6,746	5.04
7.00	00700	OPERATION OF PLANT	0	224,973	338,764	2,620	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	10,388	2,720	1,901	9.00
10.00	01000	DIETARY	0	10,865	55,602	8,224	10.00
11.00	01100	CAFETERIA	0	0	34,067	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,834	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	872	32,513	0	14.00
15.00	01500	PHARMACY	16,888	5,313	0	6,980	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,042	0	1,777	16.00
17.00	01700	SOCIAL SERVICE	0	1,768	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	54,916	0	6,147	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	73,659	0	289,120	148,325	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,923	53,983	252,274	54.00
60.00	06000	LABORATORY	0	2,920	51,846	49,178	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	19,528	21,228	28,206	18,405	65.00
66.00	06600	PHYSICAL THERAPY	0	76,374	0	14,068	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	9,900	27,890	0	4,396	88.00
91.00	09100	EMERGENCY	0	31,928	0	10,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	32,109	0	2,088	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	122,078	646,273	942,456	582,638	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,035	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	628	52,555	0	971	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	0	1,757	194.01
194.02	07952	FOUNDATION	0	1,892	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	122,706	703,755	942,456	585,366	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1341

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00540	NONPATIENT TELEPHONES	0	880				5.01
5.02	00550	DATA PROCESSING	0	118	54,028			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	61	3,347	33,728		5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	37	2,152	0	140,893	5.04
7.00	00700	OPERATION OF PLANT	0	10	478	0	8,255	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	268	8.00
9.00	00900	HOUSEKEEPING	0	7	239	0	2,719	9.00
10.00	01000	DIETARY	0	13	956	0	905	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,598	11.00
13.00	01300	NURSING ADMINISTRATION	0	10	717	0	1,910	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3	239	0	796	14.00
15.00	01500	PHARMACY	0	13	956	0	2,386	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20	956	0	1,515	16.00
17.00	01700	SOCIAL SERVICE	0	7	478	0	1,001	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,532	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	78	1,673	1,427	7,043	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27	1,912	2,202	7,761	50.00
53.00	05300	ANESTHESIOLOGY	0	3	239	611	276	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34	2,391	9,904	12,559	54.00
60.00	06000	LABORATORY	0	34	2,391	7,882	10,039	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	44	1,912	2,133	5,609	65.00
66.00	06600	PHYSICAL THERAPY	0	47	3,108	1,855	5,595	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	103	218	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,306	5,386	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	115	7,889	0	17,637	88.00
91.00	09100	EMERGENCY	0	54	1,912	4,305	15,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	51	3,108	0	9,774	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	8,847	0	4,672	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	786	45,900	33,728	124,590	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3	0	0	23	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	81	6,933	0	13,940	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	981	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	7	956	0	945	194.01
194.02	07952	FOUNDATION	0	3	239	0	414	194.02
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)	0	880	54,028	33,728	140,893	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1341

Period:
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	575,100					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	268				8.00
9.00	00900	HOUSEKEEPING	12,444	0	30,418			9.00
10.00	01000	DIETARY	28,067	0	1,533	106,165		10.00
11.00	01100	CAFETERIA	9,719	0	531	0	45,915	11.00
13.00	01300	NURSING ADMINISTRATION	2,060	0	113	0	803	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,255	0	560	0	472	14.00
15.00	01500	PHARMACY	5,968	0	326	0	829	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,663	0	309	0	1,126	16.00
17.00	01700	SOCIAL SERVICE	1,986	0	108	0	753	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,686	98	3,369	106,165	4,142	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	82,482	20	4,505	0	1,518	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,287	28	1,818	0	3,054	54.00
60.00	06000	LABORATORY	18,071	0	987	0	3,708	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,891	2	1,742	0	3,229	65.00
66.00	06600	PHYSICAL THERAPY	85,790	31	4,687	0	2,853	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	49,232	0	2,689	0	7,094	88.00
91.00	09100	EMERGENCY	35,864	89	1,959	0	6,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	36,067	0	1,655	0	1,076	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	380	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	510,532	268	26,891	106,165	37,103	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,409	0	186	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,034	0	3,225	0	7,511	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	0	0	924	194.01
194.02	07952	FOUNDATION	2,125	0	116	0	377	194.02
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)	575,100	268	30,418	106,165	45,915	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1341

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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	7,447					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	45,710				14.00
15.00	01500	PHARMACY	236	60	39,955			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	308	0	16,716		16.00
17.00	01700	SOCIAL SERVICE	214	5	0	0	6,320	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,179	9,421	0	663	5,056	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	432	7,739	0	1,024	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,355	0	284	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	870	1,633	0	4,599	0	54.00
60.00	06000	LABORATORY	1,056	1,422	0	3,663	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	920	1,387	0	991	0	65.00
66.00	06600	PHYSICAL THERAPY	812	621	0	862	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6	0	48	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	39,955	1,537	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,266	0	0	0	88.00
91.00	09100	EMERGENCY	1,728	14,081	0	2,001	1,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	2,618	0	641	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	75	0	403	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,447	43,997	39,955	16,716	6,320	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	1,536	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	164	0	0	0	194.01
194.02	07952	FOUNDATION	0	13	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,447	45,710	39,955	16,716	6,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMIN AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
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	1,532				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		263,063	0	263,063	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		620,726	0	620,726	50.00
53.00	05300	ANESTHESIOLOGY		14,863	0	14,863	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		392,357	0	392,357	54.00
60.00	06000	LABORATORY		153,197	0	153,197	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		137,227	0	137,227	65.00
66.00	06600	PHYSICAL THERAPY		196,703	0	196,703	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		375	0	375	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		50,184	0	50,184	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		130,108	0	130,108	88.00
91.00	09100	EMERGENCY		126,401	0	126,401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		89,187	0	89,187	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE		14,377	0	14,377	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,188,768	0	2,188,768	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		6,656	0	6,656	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		146,414	0	146,414	192.00
194.00	07950	HOMEBOUND MEALS		981	0	981	194.00
194.01	07951	FITNESS WELLNESS PROGRAM		4,753	0	4,753	194.01
194.02	07952	FOUNDATION		5,179	0	5,179	194.02
200.00		Cross Foot Adjustments	1,532	1,532	0	1,532	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,532	2,354,283	0	2,354,283	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NEW BDG EX (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	85,567				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	29,103			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		571,405			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,798,165		4.00
5.01	00540	NONPATIENT TELEPHONES	107	0	33,812	261	5.01
5.02	00550	DATA PROCESSING	1,935	141	32,632	345,971	35 5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,948	0	3,876	384,794	18 5.03
5.04	00590	OTHER ADMIN AND GENERAL	9,835	1,577	6,585	890,025	11 5.04
7.00	00700	OPERATION OF PLANT	27,354	10,461	2,558	238,496	3 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	1,263	84	1,856	314,381	2 9.00
10.00	01000	DIETARY	1,321	1,717	8,028	25,018	4 10.00
11.00	01100	CAFETERIA	0	1,052	0	116,265	0 11.00
13.00	01300	NURSING ADMINISTRATION	223	0	0	234,153	3 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106	1,004	0	40,538	1 14.00
15.00	01500	PHARMACY	646	0	6,814	232,540	4 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	613	0	1,735	160,101	6 16.00
17.00	01700	SOCIAL SERVICE	215	0	0	117,451	2 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,677	0	6,000	714,577	23 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	8,928	144,787	268,100	8 50.00
53.00	05300	ANESTHESIOLOGY	0	0	11,807	0	1 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,936	1,667	246,257	470,294	10 54.00
60.00	06000	LABORATORY	355	1,601	48,005	617,239	10 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	2,581	871	17,966	511,799	13 65.00
66.00	06600	PHYSICAL THERAPY	9,286	0	13,732	529,645	14 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,391	0	4,291	1,729,243	34 88.00
91.00	09100	EMERGENCY	3,882	0	9,775	1,032,894	16 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,904	0	2,038	951,953	15 101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	354,055	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,578	29,103	568,742	10,313,344	233 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	369	0	0	0	1 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,390	0	948	1,267,726	24 192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	68,769	0 194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	1,715	100,888	2 194.01
194.02	07952	FOUNDATION	230	0	0	47,438	1 194.02
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)	703,755	942,456	585,366	2,693,239	160,420 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.224608	32.383466	1.024433	0.228276	614.636015 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	880 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	3.371648 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: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description			DATA PROCESSING (# OF TERMI NALS)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVE NUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.02	5.03	5A.04	5.04	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	226					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	14	40,940,108				5.03
5.04	00590	OTHER ADMIN AND GENERAL	9	0	-1,992,477	22,766,491		5.04
7.00	00700	OPERATION OF PLANT	2	0	0	1,333,822	62,250	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	43,361	0	8.00
9.00	00900	HOUSEKEEPING	1	0	0	439,323	1,347	9.00
10.00	01000	DIETARY	4	0	0	146,179	3,038	10.00
11.00	01100	CAFETERIA	0	0	0	258,213	1,052	11.00
13.00	01300	NURSING ADMINISTRATION	3	0	0	308,614	223	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	0	0	128,694	1,110	14.00
15.00	01500	PHARMACY	4	0	0	385,481	646	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4	0	0	244,752	613	16.00
17.00	01700	SOCIAL SERVICE	2	0	0	161,751	215	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	247,595	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7	1,732,029	0	1,138,051	6,677	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8	2,672,655	0	1,253,970	8,928	50.00
53.00	05300	ANESTHESIOLOGY	1	742,024	0	44,606	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10	12,027,819	0	2,029,268	3,603	54.00
60.00	06000	LABORATORY	10	9,565,059	0	1,622,123	1,956	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8	2,588,269	0	906,297	3,452	65.00
66.00	06600	PHYSICAL THERAPY	13	2,250,834	0	904,023	9,286	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	124,491	0	35,285	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,012,056	0	870,276	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	33	0	0	2,850,961	5,329	88.00
91.00	09100	EMERGENCY	8	5,224,872	0	2,445,571	3,882	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	13	0	0	1,579,309	3,904	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	37	0	0	754,813	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	192	40,940,108	-1,992,477	20,132,338	55,261	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	3,650	369	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29	0	0	2,252,363	6,390	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	158,538	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	4	0	0	152,675	0	194.01
194.02	07952	FOUNDATION	1	0	0	66,927	230	194.02
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)	668,967	984,757		1,992,477	1,450,555	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,960.030973	0.024054		0.087518	23.302088	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,028	33,728		140,893	575,100	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	239.061947	0.000824		0.006189	9.238554	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: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,779					8.00
9.00	00900	HOUSEKEEPING	0	60,279				9.00
10.00	01000	DIETARY	0	3,038	3,929			10.00
11.00	01100	CAFETERIA	0	1,052	0	251,096		11.00
13.00	01300	NURSING ADMINISTRATION	0	223	0	4,389	143,019	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,110	0	2,579	0	14.00
15.00	01500	PHARMACY	0	646	0	4,534	4,534	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	613	0	6,157	0	16.00
17.00	01700	SOCIAL SERVICE	0	215	0	4,118	4,118	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,004	6,677	3,929	22,651	22,651	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,158	8,928	0	8,299	8,299	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,463	3,603	0	16,702	16,702	54.00
60.00	06000	LABORATORY	0	1,956	0	20,280	20,280	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	581	3,452	0	17,659	17,659	65.00
66.00	06600	PHYSICAL THERAPY	8,152	9,286	0	15,600	15,600	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,329	0	38,793	0	88.00
91.00	09100	EMERGENCY	23,421	3,882	0	33,176	33,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	3,280	0	5,886	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	2,080	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,779	53,290	3,929	202,903	143,019	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	369	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,390	0	41,080	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	0	0	5,054	0	194.01
194.02	07952	FOUNDATION	0	230	0	2,059	0	194.02
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)	47,156	509,160	255,425	314,211	348,195	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.666243	8.446723	65.010181	1.251358	2.434607	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	268	30,418	106,165	45,915	7,447	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003786	0.504620	27.020870	0.182858	0.052070	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: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	72,652					14.00
15.00	01500	PHARMACY	96	773,770				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	489	0	43,663,593			16.00
17.00	01700	SOCIAL SERVICE	8	0	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,974	0	1,732,029	80	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,300	0	2,672,655	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,154	0	742,024	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,596	0	12,027,819	0	0	54.00
60.00	06000	LABORATORY	2,260	0	9,565,059	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,205	0	2,588,269	0	0	65.00
66.00	06600	PHYSICAL THERAPY	987	0	2,250,834	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10	0	124,491	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	773,770	4,012,056	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,191	0	0	0	0	88.00
91.00	09100	EMERGENCY	22,381	0	5,224,872	20	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	4,161	0	1,672,460	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	119	0	1,051,025	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,931	773,770	43,663,593	100	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,441	0	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	260	0	0	0	0	194.01
194.02	07952	FOUNDATION	20	0	0	0	0	194.02
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)	178,425	456,677	294,540	197,932	269,264	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.455886	0.590197	0.006746	1,979.320000	2,692.640000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,710	39,955	16,716	6,320	1,532	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.629164	0.051637	0.000383	63.200000	15.320000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-2

Date/Time Prepared:
6/23/2021 3:28 pm

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		IV THERAPY AND LABORATORY		1	30.00	-66,542
8.00		IV THERAPY		1	64.00	64,753
9.00		LABORATORY		1	60.00	1,789

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
6/23/2021 3:28 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,946,142		1,946,142	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,729,431		1,729,431	0	0	50.00
53.00	05300	ANESTHESIOLOGY	328,070		328,070	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,475,292		2,475,292	0	0	54.00
60.00	06000	LABORATORY	1,972,806		1,972,806	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	64,753		64,753	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,183,564	0	1,183,564	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,358,500	0	1,358,500	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,238		39,238	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,430,183		1,430,183	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,330,956		3,330,956	0	0	88.00
91.00	09100	EMERGENCY	3,050,537		3,050,537	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	101,779		101,779		0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,865,069		1,865,069		0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	830,858		830,858		0	116.00
200.00		Subtotal (see instructions)	21,707,178	0	21,707,178	0	0	200.00
201.00		Less Observation Beds	101,779		101,779		0	201.00
202.00		Total (see instructions)	21,605,399	0	21,605,399	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
6/23/2021 3:28 pm

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,204,304		1,204,304		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,567,962	2,567,962	0.673464	50.00
53.00	05300	ANESTHESIOLOGY	5,055	713,860	718,915	0.456340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	361,330	11,438,289	11,799,619	0.209777	54.00
60.00	06000	LABORATORY	575,182	8,823,538	9,398,720	0.209902	60.00
64.00	06400	INTRAVENOUS THERAPY	139,456	314,983	454,439	0.142490	64.00
65.00	06500	RESPIRATORY THERAPY	954,007	1,618,827	2,572,834	0.460023	65.00
66.00	06600	PHYSICAL THERAPY	200,925	2,021,064	2,221,989	0.611389	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,812	56,895	120,707	0.325068	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	704,010	3,274,562	3,978,572	0.359471	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,803,300	1,803,300		88.00
91.00	09100	EMERGENCY	6,906	5,177,926	5,184,832	0.588358	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,557	61,692	67,249	1.513465	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,672,460	1,672,460		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	1,051,025	1,051,025		116.00
200.00		Subtotal (see instructions)	4,220,544	40,596,383	44,816,927		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,220,544	40,596,383	44,816,927		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE				116.00
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: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description			Title XVIII		Hospital	Cost		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	620,726	2,567,962	0.241719	0	0	50.00
53.00	05300	ANESTHESIOLOGY	14,863	718,915	0.020674	2,458	51	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	392,357	11,799,619	0.033252	202,282	6,726	54.00
60.00	06000	LABORATORY	153,197	9,398,720	0.016300	342,917	5,590	60.00
64.00	06400	INTRAVENOUS THERAPY	0	454,439	0.000000	85,273	0	64.00
65.00	06500	RESPIRATORY THERAPY	137,227	2,572,834	0.053337	512,270	27,323	65.00
66.00	06600	PHYSICAL THERAPY	196,703	2,221,989	0.088526	41,778	3,698	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	375	120,707	0.003107	42,438	132	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,184	3,978,572	0.012614	345,321	4,356	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	130,108	1,803,300	0.072150	0	0	88.00
91.00	09100	EMERGENCY	126,401	5,184,832	0.024379	3,372	82	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,758	67,249	0.204583	2,230	456	92.00
200.00		Total (lines 50 through 199)	1,835,899	40,889,138		1,580,339	48,414	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	269,264	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	269,264	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
6/23/2021 3:28 pm

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,567,962	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	269,264	0	718,915	0.374542	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,799,619	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,398,720	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	454,439	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,572,834	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,221,989	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	120,707	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,978,572	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,803,300	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	5,184,832	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	67,249	0.000000	92.00
200.00		Total (lines 50 through 199)	0	269,264	0	40,889,138		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,458	921	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	202,282	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	342,917	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	85,273	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	512,270	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	41,778	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	42,438	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	345,321	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	3,372	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,230	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,580,339	921	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
6/23/2021 3:28 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.673464	0	996,772	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.456340	0	269,347	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209777	0	4,644,581	0	0	54.00
60.00	06000	LABORATORY	0.209902	0	3,118,767	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.142490	0	205,572	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.460023	0	831,031	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.611389	0	722,231	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.325068	0	35,003	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.359471	0	2,217,311	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.588358	0	1,959,707	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.513465	0	28,165	0	0	92.00
200.00		Subtotal (see instructions)		0	15,028,487	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	15,028,487	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
6/23/2021 3:28 pm

				Title XVIII	Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	671,290	0		50.00
53.00	05300	ANESTHESIOLOGY	122,914	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	974,326	0		54.00
60.00	06000	LABORATORY	654,635	0		60.00
64.00	06400	INTRAVENOUS THERAPY	29,292	0		64.00
65.00	06500	RESPIRATORY THERAPY	382,293	0		65.00
66.00	06600	PHYSICAL THERAPY	441,564	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,378	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	797,059	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	1,153,009	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	42,627	0		92.00
200.00		Subtotal (see instructions)	5,280,387	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,280,387	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 6/23/2021 3:28 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,249	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		788	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)		724	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		433	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)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		28	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		521	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)		363	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		157.19	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)		1,946,142	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)		4,401	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00	
26.00	Total swing-bed cost (see instructions)		692,997	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,253,145	27.00	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00	
29.00	Private room charges (excluding swing-bed charges)		0	29.00	
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00	
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,253,145	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)		1,590.29	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		828,541	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)		828,541	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					532,172	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,360,713	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)					577,275	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)					577,275	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)					64	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,590.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					101,779	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
6/23/2021 3:28 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	263,063	1,946,142	0.135172	101,779	13,758
91.00	Nursing School cost	0	1,946,142	0.000000	101,779	0
92.00	Allied health cost	0	1,946,142	0.000000	101,779	0
93.00	All other Medical Education	0	1,946,142	0.000000	101,779	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 6/23/2021 3:28 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		586,458		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.673464	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.456340	2,458	1,122	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.209777	202,282	42,434	54.00
60.00	06000 LABORATORY	0.209902	342,917	71,979	60.00
64.00	06400 INTRAVENOUS THERAPY	0.142490	85,273	12,151	64.00
65.00	06500 RESPIRATORY THERAPY	0.460023	512,270	235,656	65.00
66.00	06600 PHYSICAL THERAPY	0.611389	41,778	25,543	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.325068	42,438	13,795	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359471	345,321	124,133	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.588358	3,372	1,984	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.513465	2,230	3,375	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,580,339	532,172	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,580,339		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1341 Component CCN: 14-Z341	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 6/23/2021 3:28 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.673464	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.456340	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.209777	63,785	13,381	54.00
60.00	06000 LABORATORY	0.209902	80,468	16,890	60.00
64.00	06400 INTRAVENOUS THERAPY	0.142490	12,128	1,728	64.00
65.00	06500 RESPIRATORY THERAPY	0.460023	204,822	94,223	65.00
66.00	06600 PHYSICAL THERAPY	0.611389	111,029	67,882	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.325068	6,290	2,045	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.359471	137,057	49,268	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.588358	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.513465	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		615,579	245,417	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		615,579		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 6/23/2021 3:28 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,280,387	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,280,387	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)		5,333,191	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		35,507	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,359,334	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,938,350	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,938,350	30.00
31.00	Primary payer payments		225	31.00
32.00	Subtotal (line 30 minus line 31)		2,938,125	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)		314,526	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		204,442	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		251,275	36.00
37.00	Subtotal (see instructions)		3,142,567	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)		3,142,567	40.00
40.01	Sequestration adjustment (see instructions)		20,741	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		3,472,317	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)		-350,491	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: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
6/23/2021 3:28 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,260,749		3,064,476	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	06/17/2020	240,817	3.01
3.02			0	08/26/2020	167,024	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	03/26/2020	3,804		0	3.50
3.51		06/17/2020	92,616		0	3.51
3.52		08/26/2020	140,926		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)		-237,346		407,841	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)		1,023,403		3,472,317	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		192,355		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		350,491	6.02
7.00	Total Medicare program liability (see instructions)		1,215,758		3,121,826	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: 14-1341
 Component CCN: 14-Z341

 Period:
 From 01/01/2020
 To 12/31/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 6/23/2021 3:28 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		604,725		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/17/2020	57,396		0	3.01
3.02		08/26/2020	9,257		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		66,653		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)		671,378		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		142,550		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		813,928		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 - SWING BEDS

Provider CCN: 14-1341

Period:

Worksheet E-2

Component CCN: 14-Z341

From 01/01/2020
To 12/31/2020Date/Time Prepared:
6/23/2021 3:28 pm

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		583,048	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)		247,871	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		363	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)		830,919	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		830,919	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)		830,919	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		11,583	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		819,336	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)		819,336	0	19.00
19.01	Sequestration adjustment (see instructions)		5,408	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		671,378	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)		142,550	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: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prepared: 6/23/2021 3:28 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,360,713	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,360,713	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,374,320	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,374,320	19.00
20.00	Deductibles (exclude professional component)		175,956	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,198,364	22.00
23.00	Coinsurance		1,408	23.00
24.00	Subtotal (line 22 minus line 23)		1,196,956	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		41,353	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		26,879	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		32,967	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,223,835	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,223,835	30.00
30.01	Sequestration adjustment (see instructions)		8,077	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,023,403	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)		192,355	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet G

Date/Time Prepared:
6/23/2021 3:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	12,414,627	0	0	0	1.00
2.00	Temporary investments	2,791,578	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,963,770	0	0	0	4.00
5.00	Other receivable	156,885	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	542,235	0	0	0	7.00
8.00	Prepaid expenses	107,333	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	41,183	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,017,611	0	0	0	11.00
FIXED ASSETS						
12.00	Land	51,361	0	0	0	12.00
13.00	Land improvements	3,017,777	0	0	0	13.00
14.00	Accumulated depreciation	-736,499	0	0	0	14.00
15.00	Buildings	29,256,814	0	0	0	15.00
16.00	Accumulated depreciation	-8,781,257	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	923,188	0	0	0	19.00
20.00	Accumulated depreciation	-585,469	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	9,200,290	0	0	0	23.00
24.00	Accumulated depreciation	-6,974,967	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	6,945	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,378,183	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,563,942	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,563,942	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,959,736	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	999,038	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,667,828	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	372,516	0	0	0	40.00
41.00	Deferred income	2,791,578	0	0	0	41.00
42.00	Accelerated payments	2,679,007	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	56,476	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,566,443	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,380,701	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)	7,380,701	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,947,144	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	34,012,592	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)	34,012,592	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,959,736	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-1

Date/Time Prepared:
6/23/2021 3:28 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		30,926,605		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,407,481				2.00
3.00	Total (sum of line 1 and line 2)		33,334,086		0		3.00
4.00	GAIN ON INVESTMENT IN QUAD CTY HMS	83,197		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	595,309		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)		678,506		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,012,592		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)		34,012,592		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	GAIN ON INVESTMENT IN QUAD CTY HMS		0				4.00
5.00	RESTRICTED CONTRIBUTIONS		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: 14-1341

Period:
From 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	888,820		888,820	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	296,605		296,605	5.00
6.00	Swing bed - NF	18,879		18,879	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)	1,204,304		1,204,304	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)	1,204,304		1,204,304	17.00
18.00	Ancillary services	3,003,777	31,224,480	34,228,257	18.00
19.00	Outpatient services	12,463	5,239,618	5,252,081	19.00
20.00	RURAL HEALTH CLINIC	0	1,803,642	1,803,642	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,672,460	1,672,460	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	0	1,051,025	1,051,025	26.00
27.00	PROFESSIONAL FEES	255,466	6,051,768	6,307,234	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,476,010	47,042,993	51,519,003	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,571,047		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)		27,571,047		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1341

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-3

Date/Time Prepared:
6/23/2021 3:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,519,003	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,873,332	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,645,671	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,571,047	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,925,376	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	540,119	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	43,888	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	25,839	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	486	21.00
22.00	Rental of hospital space	67,062	22.00
23.00	Governmental appropriations	0	23.00
24.00	RETAIL PHARMACY	317,191	24.00
24.01	FITNESS CENTER REVENUE	45,803	24.01
24.02	MISCELLANEOUS REVENUE	25,873	24.02
24.03	PPP LOAN FORGIVENESS	2,616,600	24.03
24.50	COVID-19 PHE Funding	1,654,633	24.50
25.00	Total other income (sum of lines 6-24)	5,337,494	25.00
26.00	Total (line 5 plus line 25)	2,412,118	26.00
27.00	LOSS ON SALE OF ASSETS	4,637	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4,637	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,407,481	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1341
HHA CCN: 14-7299
Period: From 01/01/2020 To 12/31/2020
Worksheet H
Date/Time Prepared: 6/23/2021 3:28 pm

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures		0		0	0
2.00	Capital Related - Movable Equipment		0		0	0
3.00	Plant Operation & Maintenance	0	0	0	0	0
4.00	Transportation	0	0	0	0	0
5.00	Administrative and General	121,054	0	102,331	0	319,470
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	594,408	0	0	0	594,408
7.00	Physical Therapy	115,458	0	0	76,356	191,814
8.00	Occupational Therapy	84,658	0	0	27,900	112,558
9.00	Speech Pathology	30,448	0	0	2,163	32,611
10.00	Medical Social Services	1,286	0	0	0	1,286
11.00	Home Health Aide	4,641	0	0	0	4,641
12.00	Supplies (see instructions)	0	0	0	23,316	23,316
13.00	Drugs	0	0	0	0	0
14.00	DME	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0
18.00	Clinic	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0
24.00	Total (sum of lines 1-23)	951,953	0	102,331	106,419	1,280,104
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS						
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	0
2.00	Capital Related - Movable Equipment	0	0	0	0	0
3.00	Plant Operation & Maintenance	0	0	0	0	0
4.00	Transportation	0	0	0	0	0
5.00	Administrative and General	0	319,470	0	319,470	0
HHA REIMBURSABLE SERVICES						
6.00	Skilled Nursing Care	0	594,408	0	594,408	0
7.00	Physical Therapy	0	191,814	0	191,814	0
8.00	Occupational Therapy	0	112,558	0	112,558	0
9.00	Speech Pathology	0	32,611	0	32,611	0
10.00	Medical Social Services	0	1,286	0	1,286	0
11.00	Home Health Aide	0	4,641	0	4,641	0
12.00	Supplies (see instructions)	0	23,316	0	23,316	0
13.00	Drugs	0	0	0	0	0
14.00	DME	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00	Home Dialysis Aide Services	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0
18.00	Clinic	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	1,280,104	0	1,280,104	0

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1341

Period:

Worksheet H-1

HHA CCN: 14-7299

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)		Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
				Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	0	4.00	
5.00	Administrative and General	319,470	0	0	0	0	319,470	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	594,408	0	0	0	0	594,408	6.00	
7.00	Physical Therapy	191,814	0	0	0	0	191,814	7.00	
8.00	Occupational Therapy	112,558	0	0	0	0	112,558	8.00	
9.00	Speech Pathology	32,611	0	0	0	0	32,611	9.00	
10.00	Medical Social Services	1,286	0	0	0	0	1,286	10.00	
11.00	Home Health Aide	4,641	0	0	0	0	4,641	11.00	
12.00	Supplies (see instructions)	23,316	0	0	0	0	23,316	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	1,280,104	0	0	0	0	1,280,104	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	319,470						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	197,677	792,085					6.00	
7.00	Physical Therapy	63,790	255,604					7.00	
8.00	Occupational Therapy	37,433	149,991					8.00	
9.00	Speech Pathology	10,845	43,456					9.00	
10.00	Medical Social Services	428	1,714					10.00	
11.00	Home Health Aide	1,543	6,184					11.00	
12.00	Supplies (see instructions)	7,754	31,070					12.00	
13.00	Drugs	0	0					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		1,280,104					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1341

Period:

Worksheet H-1

HHA CCN: 14-7299

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
6/23/2021 3:28 pmHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Agency 1 Reconciliation	Administrative & General (ACCUM. COST)		
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)						
		1.00	2.00						3.00
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00	
2.00	Capital Related - Movable Equipment		0			0		2.00	
3.00	Plant Operation & Maintenance	0	0	0		0		3.00	
4.00	Transportation (see instructions)	0	0	0	0			4.00	
5.00	Administrative and General	0	0	0	0	-319,470	960,634	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	594,408	6.00	
7.00	Physical Therapy	0	0	0	0	0	191,814	7.00	
8.00	Occupational Therapy	0	0	0	0	0	112,558	8.00	
9.00	Speech Pathology	0	0	0	0	0	32,611	9.00	
10.00	Medical Social Services	0	0	0	0	0	1,286	10.00	
11.00	Home Health Aide	0	0	0	0	0	4,641	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	23,316	12.00	
13.00	Drugs	0	0	0		0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	0	0	0	0	-319,470	960,634	24.00	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		319,470	25.00	
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.332562	26.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341

Period:

Worksheet H-2

HHA CCN: 14-7299

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS			Agency 1		
			BLDG & FIXT	BLDG & FIXT NEW BDG EX	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		0	1.00	1.01	2.00	4.00	5.01	
1.00	Administrative and General	0	27,931	0	2,088	27,634	1,844	1.00
2.00	Skilled Nursing Care	792,085	3,389	0	0	135,689	4,303	2.00
3.00	Physical Therapy	255,604	419	0	0	26,356	1,229	3.00
4.00	Occupational Therapy	149,991	214	0	0	19,325	615	4.00
5.00	Speech Pathology	43,456	90	0	0	6,951	0	5.00
6.00	Medical Social Services	1,714	0	0	0	294	0	6.00
7.00	Home Health Aide	6,184	66	0	0	1,059	0	7.00
8.00	Supplies (see instructions)	31,070	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	1,229	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,280,104	32,109	0	2,088	217,308	9,220	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		DATA PROCESSING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.02	5.03	5A.03	5.04	7.00	8.00	
1.00	Administrative and General	14,800	0	74,297	6,502	79,135	0	1.00
2.00	Skilled Nursing Care	14,800	0	950,266	83,165	9,600	0	2.00
3.00	Physical Therapy	2,960	0	286,568	25,080	1,188	0	3.00
4.00	Occupational Therapy	0	0	170,145	14,891	606	0	4.00
5.00	Speech Pathology	0	0	50,497	4,419	256	0	5.00
6.00	Medical Social Services	0	0	2,008	176	0	0	6.00
7.00	Home Health Aide	0	0	7,309	640	186	0	7.00
8.00	Supplies (see instructions)	0	0	31,070	2,719	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	5,920	0	7,149	626	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	38,480	0	1,579,309	138,218	90,971	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341

Period:

Worksheet H-2

HHA CCN: 14-7299

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pmHome Health
Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	23,413	0	7,365	0	0	0	1.00
2.00	Skilled Nursing Care	3,480	0	0	0	0	0	2.00
3.00	Physical Therapy	431	0	0	0	0	0	3.00
4.00	Occupational Therapy	220	0	0	0	0	0	4.00
5.00	Speech Pathology	93	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	68	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	10,219	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	27,705	0	7,365	0	10,219	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	19.00	24.00	25.00	26.00	
1.00	Administrative and General	11,282	0	0	201,994	0	201,994	1.00
2.00	Skilled Nursing Care	0	0	0	1,046,511	0	1,046,511	2.00
3.00	Physical Therapy	0	0	0	313,267	0	313,267	3.00
4.00	Occupational Therapy	0	0	0	185,862	0	185,862	4.00
5.00	Speech Pathology	0	0	0	55,265	0	55,265	5.00
6.00	Medical Social Services	0	0	0	2,184	0	2,184	6.00
7.00	Home Health Aide	0	0	0	8,203	0	8,203	7.00
8.00	Supplies (see instructions)	0	0	0	33,789	0	33,789	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	17,994	0	17,994	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	11,282	0	0	1,865,069	0	1,865,069	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341

Period:

Worksheet H-2

HHA CCN: 14-7299

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pmHome Health
Agency I

PPS

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	127,108	1,173,619		2.00
3.00	Physical Therapy	38,049	351,316		3.00
4.00	Occupational Therapy	22,574	208,436		4.00
5.00	Speech Pathology	6,712	61,977		5.00
6.00	Medical Social Services	265	2,449		6.00
7.00	Home Health Aide	996	9,199		7.00
8.00	Supplies (see instructions)	4,104	37,893		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	2,186	20,180		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	201,994	1,865,069		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.121458			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1341

Period:

Worksheet H-2

HHA CCN: 14-7299

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
6/23/2021 3:28 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMINALS)	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NEW BDG EX (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	1.01	2.00	4.00	5.01	5.02	
1.00	Administrative and General	3,396	0	2,038	121,054	3	5	1.00
2.00	Skilled Nursing Care	412	0	0	594,408	7	5	2.00
3.00	Physical Therapy	51	0	0	115,458	2	1	3.00
4.00	Occupational Therapy	26	0	0	84,658	1	0	4.00
5.00	Speech Pathology	11	0	0	30,448	0	0	5.00
6.00	Medical Social Services	0	0	0	1,286	0	0	6.00
7.00	Home Health Aide	8	0	0	4,641	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	2	2	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,904	0	2,038	951,953	15	13	20.00
21.00	Total cost to be allocated	32,109	0	2,088	217,308	9,220	38,480	21.00
22.00	Unit cost multiplier	8.224641	0.000000	1.024534	0.228276	614.666667	2,960.000000	22.00
Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.03	5A.04	5.04	7.00	8.00	9.00	
1.00	Administrative and General	0	0	74,297	3,396	0	2,772	1.00
2.00	Skilled Nursing Care	0	0	950,266	412	0	412	2.00
3.00	Physical Therapy	0	0	286,568	51	0	51	3.00
4.00	Occupational Therapy	0	0	170,145	26	0	26	4.00
5.00	Speech Pathology	0	0	50,497	11	0	11	5.00
6.00	Medical Social Services	0	0	2,008	0	0	0	6.00
7.00	Home Health Aide	0	0	7,309	8	0	8	7.00
8.00	Supplies (see instructions)	0	0	31,070	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	7,149	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0		1,579,309	3,904	0	3,280	20.00
21.00	Total cost to be allocated	0		138,218	90,971	0	27,705	21.00
22.00	Unit cost multiplier	0.000000		0.087518	23.301998	0.000000	8.446646	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1341
HHA CCN: 14-7299Period:
From 01/01/2020
To 12/31/2020Worksheet H-2
Part II
Date/Time Prepared:
6/23/2021 3:28 pm

						Home Health Agency I	6/23/2021 3:28 pm PPS	
Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	5,886	0	0	0	1,672,460	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	4,161	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	5,886	0	4,161	0	1,672,460	20.00
21.00	Total cost to be allocated	0	7,365	0	10,219	0	11,282	21.00
22.00	Unit cost multiplier	0.000000	1.251274	0.000000	2.455900	0.000000	0.006746	22.00
Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)					
		(TIME SPENT)						
		17.00	19.00					
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19)	0	0					20.00
21.00	Total cost to be allocated	0	0					21.00
22.00	Unit cost multiplier	0.000000	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet H-3

HHA CCN: 14-7299

From 01/01/2020

Part I

To 12/31/2020

Date/Time Prepared:

6/23/2021 3:28 pm

Title XVIII

Home Health
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PPS

Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,173,619		1,173,619	4,196	279.70	1.00
2.00	Physical Therapy	3.00	351,316	0	351,316	3,848	91.30	2.00
3.00	Occupational Therapy	4.00	208,436	0	208,436	1,406	148.25	3.00
4.00	Speech Pathology	5.00	61,977	0	61,977	109	568.60	4.00
5.00	Medical Social Services	6.00	2,449		2,449	16	153.06	5.00
6.00	Home Health Aide	7.00	9,199		9,199	7	1,314.14	6.00
7.00	Total (sum of lines 1-6)		1,806,996	0	1,806,996	9,582		7.00
				Program Visits				
				Part B				
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	2,364			8.00
8.01	Skilled Nursing Care		41180	0	79			8.01
9.00	Physical Therapy		99914	0	2,533			9.00
9.01	Physical Therapy		41180	0	105			9.01
10.00	Occupational Therapy		99914	0	957			10.00
10.01	Occupational Therapy		41180	0	32			10.01
11.00	Speech Pathology		99914	0	131			11.00
11.01	Speech Pathology		41180	0	2			11.01
12.00	Medical Social Services		99914	0	8			12.00
12.01	Medical Social Services		41180	0	1			12.01
13.00	Home Health Aide		99914	0	4			13.00
13.01	Home Health Aide		41180	0	0			13.01
14.00	Total (sum of lines 8-13)			0	6,216			14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	37,893	0	37,893	16,872	2.245910	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
				Program Visits		Cost of Services		
				Part B		Part B		
				Not Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		
				Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	2,443		0	683,307		1.00
2.00	Physical Therapy	0	2,638		0	240,849		2.00
3.00	Occupational Therapy	0	989		0	146,619		3.00
4.00	Speech Pathology	0	133		0	75,624		4.00
5.00	Medical Social Services	0	9		0	1,378		5.00
6.00	Home Health Aide	0	4		0	5,257		6.00
7.00	Total (sum of lines 1-6)	0	6,216		0	1,153,034		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet H-3

HHA CCN: 14-7299

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	12,194	0	0	27,387	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	683,307							1.00
2.00	Physical Therapy	240,849							2.00
3.00	Occupational Therapy	146,619							3.00
4.00	Speech Pathology	75,624							4.00
5.00	Medical Social Services	1,378							5.00
6.00	Home Health Aide	5,257							6.00
7.00	Total (sum of lines 1-6)	1,153,034							7.00
Cost Center Description									
		12.00							
	Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet H-3

HHA CCN: 14-7299

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
6/23/2021 3:28 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.611389	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.325068	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.359471	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1341

Period:

Worksheet H-4

HHA CCN: 14-7299

From 01/01/2020

Part I-II

To 12/31/2020

Date/Time Prepared:

6/23/2021 3:28 pm

Title XVIII

Home Health
Agency I

PPS

	Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	1.00
2.00	Total charges	0	1,393,108	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
4.00	Amount 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(b)	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	1,393,108	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	1,393,108	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
		Part A Services	Part B Services	
		1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	823,975	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	117,359	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	10,802	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,283	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	34,992	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	989,411	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	989,411	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	989,411	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	989,411	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	989,411	31.00
31.01	Sequestration adjustment (see instructions)	0	6,356	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	983,055	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-1341
HHA CCN: 14-7299Period:
From 01/01/2020
To 12/31/2020Worksheet H-5
Date/Time Prepared:
6/23/2021 3:28 pm

				Home Health Agency I	PPS
		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		0		983,055 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			0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50			0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		983,055 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		0 5.01
5.02			0		0 5.02
5.03			0		0 5.03
Provider to Program					
5.50			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		0		0 6.02
7.00	Total Medicare program liability (see instructions)		0		983,055 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Date/Time Prepared:
6/23/2021 3:28 pm

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	55,737	99,666	155,403	0	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	449	0	449	0	13.00
14.00	PHARMACY*	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	25.00
26.00	PHYSICIAN SERVICES**	13,579	0	13,579	0	26.00
27.00	NURSE PRACTITIONER**	1,975	0	1,975	0	27.00
28.00	REGISTERED NURSE**	198,666	0	198,666	0	28.00
29.00	LPN/LVN**	12,533	0	12,533	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	33,235	0	33,235	0	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	1,705	0	1,705	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	36,176	0	36,176	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	71,025	71,025	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	38,462	38,462	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	354,055	209,153	563,208	0	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Date/Time Prepared:
6/23/2021 3:28 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	155,403	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	449	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	13,579	26.00
27.00	NURSE PRACTITIONER**	12	1,987	27.00
28.00	REGISTERED NURSE**	1,172	199,838	28.00
29.00	LPN/LVN**	74	12,607	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	33,235	33.00
34.00	SPIRITUAL COUNSELING**	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	1,705	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	36,176	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	71,025	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	38,462	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	1,258	564,466	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE		Provider CCN: 14-1341	Period: From 01/01/2020	Worksheet 0-2
		Hospice CCN: 14-1575	To 12/31/2020	Date/Time Prepared: 6/23/2021 3:28 pm

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFICATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	13,563	0	13,563	0	13,563	26.00
27.00	NURSE PRACTITIONER	1,973	0	1,973	0	1,973	27.00
28.00	REGISTERED NURSE	198,425	0	198,425	0	198,425	28.00
29.00	LPN/LVN	12,518	0	12,518	0	12,518	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	33,195	0	33,195	0	33,195	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	1,703	0	1,703	0	1,703	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	36,132	0	36,132	0	36,132	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	70,939	70,939	0	70,939	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	38,415	38,415	0	38,415	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	297,509	109,354	406,863	0	406,863	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	13,563	26.00
27.00	NURSE PRACTITIONER	12	1,985	27.00
28.00	REGISTERED NURSE	1,172	199,597	28.00
29.00	LPN/LVN	74	12,592	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	33,195	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	1,703	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	36,132	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	70,939	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	38,415	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	1,258	408,121	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 14-1341

Period:

Worksheet 0-3

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Date/Time Prepared:
6/23/2021 3:28 pm

					Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL		
		1.00	2.00	3.00	4.00	5.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00	
26.00	PHYSICIAN SERVICES	16	0	16	0	16	26.00	
27.00	NURSE PRACTITIONER	2	0	2	0	2	27.00	
28.00	REGISTERED NURSE	241	0	241	0	241	28.00	
29.00	LPN/LVN	15	0	15	0	15	29.00	
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00	
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00	
33.00	MEDICAL SOCIAL SERVICES	40	0	40	0	40	33.00	
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00	
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00	
36.00	COUNSELING - OTHER	2	0	2	0	2	36.00	
37.00	HOSPICE AIDE & HOME MAKER SERVICES	44	0	44	0	44	37.00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00	
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00	
40.00	IMAGING SERVICES	0	0	0	0	0	40.00	
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	86	86	0	86	42.00	
42.50	DRUGS CHARGED TO PATIENTS	0	47	47	0	47	42.50	
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00	
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00	
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00	
100.00	TOTAL *	360	133	493	0	493	100.00	

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	16	26.00
27.00	NURSE PRACTITIONER	0	2	27.00
28.00	REGISTERED NURSE	0	241	28.00
29.00	LPN/LVN	0	15	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	40	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	2	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	44	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	86	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	47	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	493	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 14-1341

Period:

Worksheet 0-5

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Date/Time Prepared:
6/23/2021 3:28 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	80,822	80,822	3.00
4.00	ADMINISTRATIVE & GENERAL	155,403	178,188	333,591	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	292	292	10.00
11.00	MEDICAL RECORDS	0	7,090	7,090	11.00
12.00	STAFF TRANSPORTATION	0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	449		449	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	408,121		408,121	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	493		493	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	564,466	266,392	830,858	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0		1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0		0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	80,822		0	0	80,822		3.00
4.00	ADMINISTRATIVE & GENERAL	333,591		0	0	12,723	346,314	4.00
5.00	PLANT OPERATION & MAINTENANCE	0		0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0		0	0	0	0	6.00
7.00	HOUSEKEEPING	0		0	0	0	0	7.00
8.00	DIETARY	0		0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0		0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	292		0	0	0	292	10.00
11.00	MEDICAL RECORDS	7,090		0	0	0	7,090	11.00
12.00	STAFF TRANSPORTATION	0		0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	449		0	0	102	551	13.00
14.00	PHARMACY	0		0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0		0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0	0	0	0	17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	408,121				67,915	476,036	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	493		0	0	82	575	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0		0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0		0	0	0	0	61.00
62.00	FUNDRAISING	0		0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0		0	0	0	0	66.00
67.00	ADVERTISING	0		0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	0	0	0	68.00
69.00	THRIFT STORE	0		0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0		0	0	0	0	99.00
100.00	TOTAL	830,858		0	0	80,822	830,858	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	346,314						4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	0	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	209	0			0		10.00
11.00	MEDICAL RECORDS	5,067	0			0		11.00
12.00	STAFF TRANSPORTATION	0	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	394	0			0		13.00
14.00	PHARMACY	0	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	0	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	340,233						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	411	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	346,314	0		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	501				10.00
11.00	MEDICAL RECORDS	0		12,157			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	945	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	500	12,142	0	944	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1	15	0	1	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	501	12,157	0	945	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Part I
Date/Time Prepared:
6/23/2021 3:28 pm

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		829,855	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	1,003	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	830,858	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	354,055			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	55,737	-346,314	484,544	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	292	10.00
11.00	MEDICAL RECORDS	0	0	0	0	7,090	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	449	0	551	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			297,509	0	476,036	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	360	0	575	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	80,822		346,314	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.228275		0.714721	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	5,993					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5,993	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASISProvider CCN: 14-1341
Hospice CCN: 14-1575Period:
From 01/01/2020
To 12/31/2020Worksheet 0-6
Part II
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,599					10.00
11.00	MEDICAL RECORDS		6,599				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	6,599		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	6,591	6,591	0	6,591	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	8	8	0	8	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	501	12,157	0	945	0	100.00
101.00	UNIT COST MULTIPLIER	0.075921	1.842249	0.000000	0.143204	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Part II
Date/Time Prepared:
6/23/2021 3:28 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0	0		99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 14-1341

Period:

Worksheet 0-7

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020

Date/Time Prepared:
6/23/2021 3:28 pm

Hospice I

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
		0	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.611389	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.359471	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.209902	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.325068	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-1341

Period:

Worksheet 0-8

Hospice CCN: 14-1575

From 01/01/2020
To 12/31/2020Date/Time Prepared:
6/23/2021 3:28 pm

		Hospice I		
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0 1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0 2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00 3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0	4.00
5.00	Program cost (line 3 times line 4)	0	0	5.00
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			829,855 6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			6,591 7.00
8.00	Total average cost per diem (line 6 divided by line 7)			125.91 8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	5,907	304	9.00
10.00	Program cost (line 8 times line 9)	743,750	38,277	10.00
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			1,003 11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			8 12.00
13.00	Total average cost per diem (line 11 divided by line 12)			125.38 13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	8	0	14.00
15.00	Program cost (line 13 times line 14)	1,003	0	15.00
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			0 16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0 17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00 18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0	19.00
20.00	Program cost (line 18 times line 19)	0	0	20.00
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			830,858 21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			6,599 22.00
23.00	Average cost per diem (line 21 divided by line 22)			125.91 23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341

Period:

Worksheet M-1

Component CCN: 14-8508

From 01/01/2020
To 12/31/2020Date/Time Prepared:
6/23/2021 3:28 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	620,161	0	620,161	-89,923	530,238
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	460,257	0	460,257	-43,310	416,947
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	378,177	0	378,177	0	378,177
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	1,458,595	0	1,458,595	-133,233	1,325,362
11.00	Physician Services Under Agreement	26,042	0	26,042	0	26,042
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)	26,042	0	26,042	0	26,042
15.00	Medical Supplies	0	80,052	80,052	0	80,052
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	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	80,052	80,052	0	80,052
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,484,637	80,052	1,564,689	-133,233	1,431,456
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	133,233	133,233
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	2,073	2,073	0	2,073
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,073	2,073	133,233	135,306
FACILITY OVERHEAD						
29.00	Facility Costs	0	10,903	10,903	0	10,903
30.00	Administrative Costs	244,606	482,130	726,736	948	727,684
31.00	Total Facility Overhead (sum of lines 29 and 30)	244,606	493,033	737,639	948	738,587
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,729,243	575,158	2,304,401	948	2,305,349

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341

Period:

Worksheet M-1

Component CCN: 14-8508

From 01/01/2020
To 12/31/2020Date/Time Prepared:
6/23/2021 3:28 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	530,238	1.00	
2.00	Physician Assistant	0	0	2.00	
3.00	Nurse Practitioner	0	416,947	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	378,177	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	1,325,362	10.00	
11.00	Physician Services Under Agreement	0	26,042	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	26,042	14.00	
15.00	Medical Supplies	0	80,052	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	80,052	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,431,456	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	133,233	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	2,073	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	135,306	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	10,903	29.00	
30.00	Administrative Costs	0	727,684	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	738,587	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,305,349	32.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1341 Component CCN: 14-8508		Period: From 01/01/2020 To 12/31/2020		Worksheet M-2 Date/Time Prepared: 6/23/2021 3:28 pm	
			RHC I		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4			
	1.00	2.00	3.00	4.00	5.00			
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	1.42	5,956	4,200	5,964			1.00
2.00	Physician Assistant	0.00	0	2,100	0			2.00
3.00	Nurse Practitioner	2.47	5,056	1,995	4,928			3.00
4.00	Subtotal (sum of lines 1 through 3)	3.89	11,012		10,892	11,012		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	215			215		7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0		7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0		7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.89	11,227			11,227		8.00
9.00	Physician Services Under Agreements		0			0		9.00
							1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES								
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,431,456		10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					135,306		11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,566,762		12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.913640		13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					738,587		14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,025,607		15.00
16.00	Total overhead (sum of lines 14 and 15)					1,764,194		16.00
17.00	Allowable GME overhead (see instructions)					0		17.00
18.00	Enter the amount from line 16					1,764,194		18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,611,838		19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,043,294		20.00

Health Financial Systems		PANA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1341	Period: From 01/01/2020 To 12/31/2020	Worksheet M-3	
		Component CCN: 14-8508		Date/Time Prepared: 6/23/2021 3:28 pm	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,043,294	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			58,751	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,984,543	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,227	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)			11,227	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			265.84	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		265.84	265.84	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,321	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	617,015	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	617,015	16.00
16.01	Total program charges (see instructions)(from contractor's records)			513,830	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			18,607	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			22,343	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.)			425,760	16.04
16.05	Total program cost (see instructions)		0	448,103	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			62,472	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			85,799	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			448,103	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			14,842	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			462,945	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			462,945	26.00
26.01	Sequestration adjustment (see instructions)			3,055	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			377,436	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)			82,454	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: 14-1341 Component CCN: 14-8508	Period: From 01/01/2020 To 12/31/2020	Worksheet M-4 Date/Time Prepared: 6/23/2021 3:28 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,325,362	1,325,362	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000362	0.000912	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		480	1,209	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		24,214	1,731	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		24,694	2,940	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,431,456	1,431,456	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,611,838	1,611,838	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.017251	0.002054	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		27,806	3,311	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		52,500	6,251	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		138	348	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		380.43	17.96	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		35	85	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		13,315	1,527	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)			58,751	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)			14,842	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1341 Component CCN: 14-8508	Period: From 01/01/2020 To 12/31/2020	Worksheet M-5 Date/Time Prepared: 6/23/2021 3:28 pm	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			372,487	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			06/17/2020	4,949	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			4,949	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			377,436	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			82,454	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			459,890	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00