

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: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet S Parts I-III Date/Time Prepared: 10/29/2020 9:00 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 10/29/2020	Time: 9:00 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CRAWFORD MEMORIAL HOSPITAL (14-1343) for the cost reporting period beginning 05/01/2019 and ending 04/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) AL WHITE

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	121,123	278,432	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER (SPECIFY) I						4.00
5.00	Swing Bed - SNF	0	-107,703	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		209,027		0	10.00
10.01	RURAL HEALTH CLINIC II	0		73,551		0	10.01
10.02	RURAL HEALTH CLINIC III	0		52,629		0	10.02
200.00	Total	0	13,420	613,639	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: 14-1343		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 10/29/2020 9:00 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1000 NORTH ALLEN STREET			PO Box:				1.00		
2.00	City: ROBINSON			State: IL		Zip Code: 62454		County: CRAWFORD		
		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		CRAWFORD MEMORIAL HOSPITAL	141343	99914	1	05/01/2005	N	O	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		CRAWFORD MEMORIAL HOSPITAL	14Z343	99914		05/01/2005	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		CRAWFORD MEMORIAL HOSPITAL LTC	146150	99914		03/29/2012	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		CRAWFORD MEMORIAL HHA	147175	99914		08/01/1979	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		CMH RURAL HEALTH CLINIC	143429	99914		11/11/1996	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		PALESTINE RURAL HEALTH CLINIC	143486	99914		11/21/2006	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		OBLONG RURAL HEALTH CLINIC	143488	99914		05/01/2007	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)						05/01/2019	04/30/2020		20.00
21.00	Type of Control (see instructions)						11			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
10/29/2020 9:00 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1343		Period: From 05/01/2019 To 04/30/2020		Worksheet S-2 Part I Date/Time Prepared: 10/29/2020 9:00 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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	0.000000

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part I
Date/Time Prepared:
10/29/2020 9:00 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 10/29/2020 9:00 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
			V 1.00	XIX 2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	N	N
			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: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 10/29/2020 9:00 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part I Date/Time Prepared: 10/29/2020 9:00 am		
1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:	Contractor's Name:		Contractor's Number:		
142.00	Street:	PO Box:				
143.00	City:	State:		Zip Code:		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?				Y	
				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	
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.					
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	Y	Y	N	N	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER (SPECIFY)					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
				1.00		
Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	
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)					
168.01	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)					
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	
				Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					
				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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet S-2 Part II Date/Time Prepared: 10/29/2020 9:00 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/24/2020	Y 09/24/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
10/29/2020 9:00 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARK	DALLAS		41.00
42.00	Enter the employer/company name of the cost report preparer.	KEB			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6185291040	MARKD@KEBCPA.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet S-2
Part II
Date/Time Prepared:
10/29/2020 9:00 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	49,800.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	49,800.00	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	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	49,800.00	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 (SPECIFY)	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	35	12,775		0	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						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		60				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: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,012	36	2,075			1.00
2.00	HMO and other (see instructions)	73	329				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	853	0	921			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	49			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,865	36	3,045			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		68	281			13.00
14.00	Total (see instructions)	1,865	104	3,326	0.00	285.99	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 (SPECIFY)		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	1,038	0	4,782	0.00	19.60	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	1,525	333	3,344	0.00	7.77	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	6,443	0	25,700	0.00	35.56	26.00
26.01	RURAL HEALTH CLINIC II	504	0	2,687	0.00	4.19	26.01
26.02	RURAL HEALTH CLINIC III	778	0	5,820	0.00	8.50	26.02
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	361.61	27.00
28.00	Observation Bed Days		0	385			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	33	65			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: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet S-3
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	432	46	1,046	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	432	46	1,046	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER (SPECIFY)	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					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						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
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: 14-1343 Component CCN: 14-7175		Period: From 05/01/2019 To 04/30/2020		Worksheet S-4 Date/Time Prepared: 10/29/2020 9:00 am	
				Home Health Agency I		PPS	
				1.00			
0.00 County				CLICK HERE TO ENTER		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	1,105	0	1,318	2,423	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		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		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.01	0.00	1.01	4.00
5.00	Other Administrative Personnel			1.01	0.00	1.01	5.00
6.00	Direct Nursing Service			4.00	0.00	4.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.75	0.00	0.75	8.00
9.00	Physical Therapy Supervisor			0.37	0.00	0.37	9.00
10.00	Occupational Therapy Service			0.14	0.00	0.14	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.28	0.00	1.28	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.			1			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
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	755	23	10	0	788	21.00
22.00	Skilled Nursing Visit Charges	169,875	5,175	2,250	0	177,300	22.00
23.00	Physical Therapy Visits	409	11	1	0	421	23.00
24.00	Physical Therapy Visit Charges	94,479	2,541	231	0	97,251	24.00
25.00	Occupational Therapy Visits	89	0	0	0	89	25.00
26.00	Occupational Therapy Visit Charges	20,559	0	0	0	20,559	26.00
27.00	Speech Pathology Visits	22	0	0	0	22	27.00
28.00	Speech Pathology Visit Charges	5,082	0	0	0	5,082	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	202	3	0	0	205	31.00
32.00	Home Health Aide Visit Charges	21,614	321	0	0	21,935	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,477	37	11	0	1,525	33.00
34.00	Other Charges	14,094	996	20	0	15,110	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	325,703	9,033	2,501	0	337,237	35.00
36.00	Total Number of Episodes (standard/non outlier)	93		0	0	93	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1343 Component CCN: 14-3429		Period: From 05/01/2019 To 04/30/2020 Worksheet S-8 Date/Time Prepared: 10/29/2020 9:00 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1000 N ALLEN		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ROBINSON IL 62454		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		08:00	17:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County		4.00	
2.00	City, State, ZIP Code, County	CRAWFORD		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		1.00		2.00	
11.00	Facility hours of operations (1)	CLINIC		17:00	08:00
		17:00		08:00	17:00
		1.00		2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1343 Component CCN: 14-3429	Period: From 05/01/2019 To 04/30/2020	Worksheet S-8 Date/Time Prepared: 10/29/2020 9:00 am	
			RHC I		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1343 Component CCN: 14-3486		Period: From 05/01/2019 To 04/30/2020 Worksheet S-8 Date/Time Prepared: 10/29/2020 9:00 am	
		RHC II		Cost	
		1.00			
1.00	Clinic Address and Identification		209 EAST GRAND PRAIRIE		1.00
	Street	City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		PALESTINE IL 62451		2.00
			1.00		
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0		3.00
	Grant Award		Date		
	1.00		2.00		
	Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER				9.00
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
	Sunday		Monday		Tuesday
	from	to	from	to	from
	1.00	2.00	3.00	4.00	5.00
11.00	Facility hours of operations (1)				
	CLINIC		08:00	16:30	08:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
	Provider name		CCN number		
	1.00		2.00		
14.00	RHC/FQHC name, CCN number				14.00
	Y/N	V	XVIII	XIX	Total Visits
	1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
	County				
	4.00				
2.00	City, State, ZIP Code, County		CRAWFORD		2.00
	Tuesday	Wednesday	Thursday		
	to	from	to	from	to
	6.00	7.00	8.00	9.00	10.00
11.00	Facility hours of operations (1)				
	CLINIC	16:30	08:00	16:30	08:00
					16:30
					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1343

Period:

Worksheet S-8

Component CCN: 14-3486

From 05/01/2019
To 04/30/2020

Date/Time Prepared:

10/29/2020 9:00 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	16:30				11.00

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1343 Component CCN: 14-3488		Period: From 05/01/2019 To 04/30/2020 Worksheet S-8 Date/Time Prepared: 10/29/2020 9:00 am	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1000 N ALLEN		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ROBINSON IL 62454		2.00	
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	CRAWFORD		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1343 Component CCN: 14-3488	Period: From 05/01/2019 To 04/30/2020	Worksheet S-8 Date/Time Prepared: 10/29/2020 9:00 am	
			RHC III		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet S-10

Date/Time Prepared:
10/29/2020 9:00 am

				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.503331	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			4,226,034	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			2,357,940	5.00	
6.00	Medicaid charges			23,821,435	6.00	
7.00	Medicaid cost (line 1 times line 6)			11,990,067	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)			5,406,093	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			5,406,093	19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
Uncompensated Care (see instructions for each line)						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)			1,556,407	916,404	2,472,811
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)			783,388	916,404	1,699,792
22.00	Payments received from patients for amounts previously written off as charity care			96,497	56,817	153,314
23.00	Cost of charity care (line 21 minus line 22)			686,891	859,587	1,546,478
				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)			2,269,870		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			276,851		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			425,926		27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,843,944		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,077,189		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,623,667		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8,029,760		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,871,439	2,871,439	1,240,381	4,111,820	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,860,455	1,860,455	0	1,860,455	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	203,523	4,296,340	4,499,863	1,575	4,501,438	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	26,273	26,273	5.01
5.02	00550	DATA PROCESSING	254,020	2,157,162	2,411,182	0	2,411,182	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	160,173	91,451	251,624	0	251,624	5.03
5.04	00570	ADMITTING	487,449	53,440	540,889	-26,711	514,178	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	672,417	616,817	1,289,234	0	1,289,234	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,421,111	2,639,614	4,060,725	0	4,060,725	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	440,186	1,292,823	1,733,009	41,346	1,774,355	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	84,901	45,490	130,391	0	130,391	8.00
9.00	00900	HOUSEKEEPING	374,538	174,957	549,495	0	549,495	9.00
10.00	01000	DIETARY	493,724	400,038	893,762	-534,838	358,924	10.00
11.00	01100	CAFETERIA	0	0	0	534,838	534,838	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	625,760	52,149	677,909	0	677,909	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	634,284	2,372,006	3,006,290	0	3,006,290	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375,451	179,678	555,129	0	555,129	16.00
17.00	01700	SOCIAL SERVICE	58,503	5,272	63,775	0	63,775	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,975,053	431,236	3,406,289	-150,757	3,255,532	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	11,883	11,883	44,451	56,334	43.00
44.00	04400	SKILLED NURSING FACILITY	805,550	163,560	969,110	438	969,548	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	893,993	368,904	1,262,897	1,085,769	2,348,666	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	-48	-48	106,306	106,258	52.00
53.00	05300	ANESTHESIOLOGY	968,469	117,300	1,085,769	-1,085,769	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	717,580	913,720	1,631,300	-6,722	1,624,578	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	145,125	37,300	182,425	0	182,425	54.01
60.00	06000	LABORATORY	659,607	1,007,690	1,667,297	-88,901	1,578,396	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	88,901	88,901	88,901	177,802	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	422,629	154,023	576,652	0	576,652	65.00
66.00	06600	PHYSICAL THERAPY	1,134,673	231,615	1,366,288	-73,037	1,293,251	66.00
69.00	06900	ELECTROCARDIOLOGY	7,910	2,240	10,150	0	10,150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	822,008	822,008	-285,762	536,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	298,950	298,950	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,722	6,722	73.00
76.00	03950	CARDIAC REHAB	0	8,762	8,762	0	8,762	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,514,107	963,088	4,477,195	-23,727	4,453,468	88.00
88.01	08801	RURAL HEALTH CLINIC II	267,779	100,610	368,389	0	368,389	88.01
88.02	08802	RURAL HEALTH CLINIC III	734,799	152,663	887,462	10,481	897,943	88.02
90.00	09000	CLINIC	1,690,043	1,840,596	3,530,639	-7,201	3,523,438	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	192,512	21,043	213,555	0	213,555	90.01
91.00	09100	EMERGENCY	897,776	1,884,544	2,782,320	0	2,782,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	422,124	105,611	527,735	52,064	579,799	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		1,240,381	1,240,381	-1,240,381	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,735,769	29,776,761	52,512,530	14,689	52,527,219	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	5,680	-3,552	2,128	13,246	15,374	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	-3,526	-3,526	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	111,760	111,760	-22,834	88,926	194.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
194.02	07952	FOUNDATION SERVICES	58,881	4,955	63,836	0	63,836	194.02
194.03	07953	WELLNESS	66,099	17,836	83,935	-1,575	82,360	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	22,866,429	29,907,760	52,774,189	0	52,774,189	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-667,841	3,443,979	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,860,455	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-381,958	4,119,480	4.00
5.01	00540	NONPATIENT TELEPHONES	0	26,273	5.01
5.02	00550	DATA PROCESSING	0	2,411,182	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	251,624	5.03
5.04	00570	ADMITTING	0	514,178	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,289,234	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-348,368	3,712,357	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-1,440	1,772,915	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	130,391	8.00
9.00	00900	HOUSEKEEPING	0	549,495	9.00
10.00	01000	DIETARY	0	358,924	10.00
11.00	01100	CAFETERIA	-181,654	353,184	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	677,909	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-11,971	2,994,319	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,852	550,277	16.00
17.00	01700	SOCIAL SERVICE	0	63,775	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,115,989	2,139,543	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	42.00
43.00	04300	NURSERY	-9,500	46,834	43.00
44.00	04400	SKILLED NURSING FACILITY	0	969,548	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-819,314	1,529,352	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	106,258	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-338,920	1,285,658	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	182,425	54.01
60.00	06000	LABORATORY	0	1,578,396	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	177,802	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-27,160	549,492	65.00
66.00	06600	PHYSICAL THERAPY	-172	1,293,079	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	536,246	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	298,950	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,722	73.00
76.00	03950	CARDIAC REHAB	0	8,762	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-346,086	4,107,382	88.00
88.01	08801	RURAL HEALTH CLINIC II	-44,788	323,601	88.01
88.02	08802	RURAL HEALTH CLINIC III	-10,347	887,596	88.02
90.00	09000	CLINIC	-2,857,954	665,484	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	213,555	90.01
91.00	09100	EMERGENCY	-1,342,786	1,439,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	579,799	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,511,100	44,016,119	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,374	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	-3,526	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	88,926	194.01
194.02	07952	FOUNDATION SERVICES	0	63,836	194.02
194.03	07953	WELLNESS	0	82,360	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
194.04	07954	RENTED SPACE	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,511,100	44,263,089	200.00

RECLASSIFICATIONS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet A-6
Date/Time Prepared:
10/29/2020 9:00 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - LTC ADMITTING COSTS					
1.00	SKILLED NURSING FACILITY	44.00	392	46		1.00
	TOTALS		392	46		
	B - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	295,450	239,388		1.00
	TOTALS		295,450	239,388		
	C - COST OF BLOOD					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	88,901		1.00
	TOTALS		0	88,901		
	D - HHA MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	13,188		1.00
	TOTALS		0	13,188		
	E - PBX COSTS					
1.00	NONPATIENT TELEPHONES	5.01	23,509	2,764		1.00
	TOTALS		23,509	2,764		
	H - LABOR/DEL & NB COSTS					
1.00	NURSERY	43.00	48,364	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	91,265	15,041		2.00
	TOTALS		139,629	15,041		
	I - RADIOLOGY CONTRAST ISOVIEW DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,722		1.00
	TOTALS		0	6,722		
	J - OR COST					
1.00	OPERATING ROOM	50.00	968,469	117,300		1.00
	TOTALS		968,469	117,300		
	K - R/C PALESTINE OBLONG DRS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,246		1.00
2.00	RURAL HEALTH CLINIC III	88.02	0	10,481		2.00
	TOTALS		0	23,727		
	L - HEALTHWORKS COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,240	335		1.00
	TOTALS		1,240	335		
	M - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	41,346		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	41,346		
	N - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,240,381		1.00
	TOTALS		0	1,240,381		
	P - PROPERTY TAX PT					
1.00	PHYSICAL THERAPY	66.00	0	22,834		1.00
	TOTALS		0	22,834		
	Q - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	298,950		1.00
	TOTALS		0	298,950		
	U - RECLASS HHA SALARY IN THERAPY					
1.00	HOME HEALTH AGENCY	101.00	65,252	0		1.00
	TOTALS		65,252	0		
500.00	Grand Total: Increases		1,493,941	2,110,923		500.00

RECLASSIFICATIONS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet A-6
Date/Time Prepared:
10/29/2020 9:00 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - LTC ADMITTING COSTS						
1.00	ADMITTING	5.04	392	46	0		1.00
	TOTALS		392	46			
	B - CAFETERIA COSTS						
1.00	DIETARY	10.00	295,450	239,388	0		1.00
	TOTALS		295,450	239,388			
	C - COST OF BLOOD						
1.00	LABORATORY	60.00	0	88,901	0		1.00
	TOTALS		0	88,901			
	D - HHA MED SUPPLIES						
1.00	HOME HEALTH AGENCY	101.00	0	13,188	0		1.00
	TOTALS		0	13,188			
	E - PBX COSTS						
1.00	ADMITTING	5.04	23,509	2,764	0		1.00
	TOTALS		23,509	2,764			
	H - LABOR/DEL & NB COSTS						
1.00	ADULTS & PEDIATRICS	30.00	139,629	11,128	0		1.00
2.00	NURSERY	43.00	0	3,913	0		2.00
	TOTALS		139,629	15,041			
	I - RADIOLOGY CONTRAST ISOVIEW DRUGS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,722	0		1.00
	TOTALS		0	6,722			
	J - OR COST						
1.00	ANESTHESIOLOGY	53.00	968,469	117,300	0		1.00
	TOTALS		968,469	117,300			
	K - R/C PALESTINE OBLONG DRS						
1.00	RURAL HEALTH CLINIC	88.00	0	23,727	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	23,727			
	L - HEALTHWORKS COSTS						
1.00	WELLNESS	194.03	1,240	335	0		1.00
	TOTALS		1,240	335			
	M - UTILITIES						
1.00	PHYSICAL THERAPY	66.00	0	30,619	0		1.00
2.00	CLINIC	90.00	0	7,201	0		2.00
3.00	NONREIMBURSEABLE	194.00	0	3,526	0		3.00
	TOTALS		0	41,346			
	N - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,240,381	11		1.00
	TOTALS		0	1,240,381			
	P - PROPERTY TAX PT						
1.00	PROFESSIONAL BUILDINGS	194.01	0	22,834	0		1.00
	TOTALS		0	22,834			
	Q - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	298,950	0		1.00
	TOTALS		0	298,950			
	U - RECLASS HHA SALARY IN THERAPY						
1.00	PHYSICAL THERAPY	66.00	65,252	0	0		1.00
	TOTALS		65,252	0			
500.00	Grand Total: Decreases		1,493,941	2,110,923			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part I
Date/Time Prepared:
10/29/2020 9:00 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	616,085	0	0	0	0	1.00
2.00	Land Improvements	1,282,487	43,230	0	43,230	0	2.00
3.00	Buildings and Fixtures	54,744,176	1,813,816	0	1,813,816	36,772	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	19,472,520	727,029	0	727,029	71,250	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,115,268	2,584,075	0	2,584,075	108,022	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,115,268	2,584,075	0	2,584,075	108,022	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	616,085	0				1.00
2.00	Land Improvements	1,325,717	0				2.00
3.00	Buildings and Fixtures	56,521,220	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	20,128,299	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	78,591,321	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	78,591,321	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part II
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,871,439	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,860,455	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,731,894	0	0	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	2,871,439				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,860,455				2.00
3.00	Total (sum of lines 1-2)	0	4,731,894				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet A-7
Part III
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	56,642,748	0	56,642,748	0.737814	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,128,299	0	20,128,299	0.262186	0	2.00
3.00	Total (sum of lines 1-2)	76,771,047	0	76,771,047	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,871,439	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,860,455	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,731,894	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	784,410	0	0	-211,870	3,443,979	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,860,455	2.00
3.00	Total (sum of lines 1-2)	784,410	0	0	-211,870	5,304,434	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-211,870	CAP REL COSTS-BLDG & FIXT	1.00	14	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,720,741			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	-181,654	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	-4,852	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-172	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8

Date/Time Prepared:
10/29/2020 9:00 am

			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	
33.00 PHYS RECRUITING	A	-68,000	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.00
33.11 EMPLOYEE INJURY	A	-665	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.22 EMPLOYEE PHYSICIANS	A	-10,524	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.22
34.00 ADVERTISING	A	-143,811	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	34.00
35.00 TV ADMINISTRATION	A	-10,745	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	35.00
36.00 TV UTILITIES & REPAIR	A	-1,440	OPERATION OF PLANT	7.00	0	36.00
38.00 EMPLOYEE DISCOUNTS	A	-88,041	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
40.00 OTHER A&G	B	-13,445	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	40.00
42.00 CONSULTING CLINIC	B	-46,943	CLINIC	90.00	0	42.00
42.01 EMPLOYEE SALES - PHARMACY	B	-11,971	PHARMACY	15.00	0	42.01
42.11 OTHER INCOME ROBINSON RHC	B	-6,465	RURAL HEALTH CLINIC	88.00	0	42.11
44.00 OTHER INCOME PALESTINE	B	0	RURAL HEALTH CLINIC II	88.01	0	44.00
46.00 PHYSICIAN AND MID LEVEL EXPENSES	A	0	CLINIC	90.00	0	46.00
47.00 CRNA BENEFITS	A	0	OPERATING ROOM	50.00	0	47.00
48.00 PHYSICIAN BENEFITS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
48.01 PHYSICIAN AND MID LEVEL EXPENSES	A	-284,700	RURAL HEALTH CLINIC	88.00	0	48.01
48.02 PHYSICIAN AND MID LEVEL EXPENSES	A	-42,000	RURAL HEALTH CLINIC II	88.01	0	48.02
48.03 PHYSICIAN AND MID LEVEL EXPENSES	A	-54,921	RURAL HEALTH CLINIC	88.00	0	48.03
48.04 PHYSICIAN AND MID LEVEL EXPENSES	A	-2,788	RURAL HEALTH CLINIC II	88.01	0	48.04
48.15 PHYSICIAN AND MID LEVEL EXPENSES	A	-10,347	RURAL HEALTH CLINIC III	88.02	0	48.15
48.25 OTHER A&G	A	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	48.25
49.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.00
49.01 NONALLOW CARELINK COST	A	0		0.00	0	49.01
49.02 MISC INCOME	B	-41,008	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	49.02
49.03 AHA & IHA DUES	A	-13,038	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	49.03
49.04 OB LOCUM TENUMS	A	0	ADULTS & PEDIATRICS	30.00	0	49.04
49.05 NONPATIENT CPR	B	-5,093	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	49.05
49.06 OTHER INCOME DIETITIAN	B	-26,167	CLINIC	90.00	0	49.06
49.07 DONATIONS, PROJECTS	B	-53,228	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	49.07
49.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.08
49.13 ADMIN CLAIMS FEES	A	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	49.13
49.14 AMORT BOND ISSUE COST	A	25,705	CAP REL COSTS-BLDG & FIXT	1.00	11	49.14
49.20 MRI RENT	B	-500	RADIOLOGY-DIAGNOSTIC	54.00	0	49.20
49.30 BOND ISSUANCE COST	A	-481,676	CAP REL COSTS-BLDG & FIXT	1.00	11	49.30
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,511,100				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-1

Date/Time Prepared:
10/29/2020 9:00 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	90.01	PAIN MANAGEMENT CLINIC	SALARIES	192,512	192,512	1.00
2.00	90.01	PAIN MANAGEMENT CLINIC	OTHER EXPENSES	21,043	21,043	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			213,555	213,555	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	CRAWFORD MEM HOSP PAIN MGMT LLC	51.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-1

Date/Time Prepared:
10/29/2020 9:00 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	0			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	
Type of Business	
6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	PAIN MANAGEMENT SERVICES	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-2

Date/Time Prepared:

10/29/2020 9:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	51,199	51,199	0	0	0	1.00
2.00	43.00	AGGREGATE-NURSERY	9,500	9,500	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	4,325	4,325	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	338,420	338,420	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	27,160	27,160	0	0	0	5.00
6.00	0.00	AGGREGATE-	0	0	0	0	0	6.00
7.00	0.00	AGGREGATE-	0	0	0	0	0	7.00
8.00	90.00	AGGREGATE-CLINIC	1,507,400	1,507,400	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	1,717,675	1,342,786	374,889	0	0	9.00
10.00	90.00	AGGREGATE-CLINIC	1,277,444	1,277,444	0	0	0	10.00
11.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTMENT	282,728	282,728	0	0	0	11.00
12.00	0.00	AGGREGATE-	0	0	0	0	0	12.00
13.00	0.00	AGGREGATE-	0	0	0	0	0	13.00
14.00	0.00	AGGREGATE-	0	0	0	0	0	14.00
15.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,064,790	1,064,790	0	0	0	15.00
16.00	50.00	AGGREGATE-OPERATING ROOM	814,989	814,989	0	0	0	16.00
200.00			7,095,630	6,720,741	374,889		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	0.00	AGGREGATE-	0	0	0	0	0	6.00
7.00	0.00	AGGREGATE-	0	0	0	0	0	7.00
8.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	8.00
9.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	9.00
10.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	10.00
11.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	11.00
12.00	0.00	AGGREGATE-	0	0	0	0	0	12.00
13.00	0.00	AGGREGATE-	0	0	0	0	0	13.00
14.00	0.00	AGGREGATE-	0	0	0	0	0	14.00
15.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	15.00
16.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	16.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	51,199		1.00
2.00	43.00	AGGREGATE-NURSERY	0	0	0	9,500		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	4,325		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	338,420		4.00
5.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	27,160		5.00
6.00	0.00	AGGREGATE-	0	0	0	0		6.00
7.00	0.00	AGGREGATE-	0	0	0	0		7.00
8.00	90.00	AGGREGATE-CLINIC	0	0	0	1,507,400		8.00
9.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,342,786		9.00
10.00	90.00	AGGREGATE-CLINIC	0	0	0	1,277,444		10.00
11.00	4.00	AGGREGATE-EMPLOYEE BENEFITS DEPARTMENT	0	0	0	282,728		11.00
12.00	0.00	AGGREGATE-	0	0	0	0		12.00
13.00	0.00	AGGREGATE-	0	0	0	0		13.00
14.00	0.00	AGGREGATE-	0	0	0	0		14.00
15.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,064,790		15.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet A-8-2

Date/Time Prepared:
10/29/2020 9:00 am

	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		
16.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	814,989		16.00
200.00			0	0	0	6,720,741		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1343		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 10/29/2020 9:00 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					164	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,280.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	86.36	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)	43.18	43.18	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)					110,584	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)					110,584	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)					110,584	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					110,584	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)					7,082	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)					7,082	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					7,082	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)					7,082	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 FORTHERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS				Provider CCN: 14-1343		Period: From 05/01/2019 To 04/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 10/29/2020 9:00 am	
						Physical Therapy		Cost	
								1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
				Therapists	Assistants	Aides	Trainees	Total	
				1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	3.50	0.00	0.00	0.00	0.00	3.50		47.00
48.00	Overtime rate (see instructions)	129.54	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)	453.39	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)	100.00	0.00	0.00	0.00	0.00	100.00		50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	0.00	2,080.00		51.00
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	86.36	0.00	0.00	0.00	0.00			52.00
53.00	Overtime cost limitation (line 51 times line 52)	179,629	0	0	0	0			53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	453	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)	302	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.)	151	0	0	0	0	151		56.00
								1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							110,584	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							7,082	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)							151	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)							117,817	63.00
64.00	Total cost of outside supplier services (from your records)							117,989	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							172	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							7,082	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							7,082	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							0	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,443,979	3,443,979			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,860,455		1,860,455		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,119,480	19,069	142	4,138,691	4.00
5.01	00540	NONPATIENT TELEPHONES	26,273	0	0	4,873	5.01
5.02	00550	DATA PROCESSING	2,411,182	17,021	719,221	52,655	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	251,624	48,685	810	33,202	5.03
5.04	00570	ADMITTING	514,178	16,096	1,449	96,088	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,289,234	26,622	3,286	139,384	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	3,712,357	199,364	7,190	294,579	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,772,915	181,110	68,565	91,245	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,391	55,907	3,041	17,599	8.00
9.00	00900	HOUSEKEEPING	549,495	18,232	662	77,637	9.00
10.00	01000	DIETARY	358,924	80,944	13,043	41,100	10.00
11.00	01100	CAFETERIA	353,184	43,290	0	61,243	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	677,909	14,929	0	129,713	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	2,994,319	27,921	91,814	131,479	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	550,277	68,437	10,478	77,826	16.00
17.00	01700	SOCIAL SERVICE	63,775	1,850	0	12,127	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,139,543	293,696	78,715	393,600	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	42.00
43.00	04300	NURSERY	46,834	13,982	0	10,025	43.00
44.00	04400	SKILLED NURSING FACILITY	969,548	239,704	24,933	167,062	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,529,352	456,881	323,679	227,600	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	106,258	28,846	0	18,918	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,285,658	74,800	330,079	148,746	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	182,425	10,679	2,245	30,083	54.01
60.00	06000	LABORATORY	1,578,396	37,609	13,401	136,729	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	177,802	2,422	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	549,492	33,734	29,647	87,606	65.00
66.00	06600	PHYSICAL THERAPY	1,293,079	220,701	3,768	221,678	66.00
69.00	06900	ELECTROCARDIOLOGY	10,150	5,989	0	1,640	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	536,246	16,493	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	298,950	5,747	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,722	0	0	0	73.00
76.00	03950	CARDIAC REHAB	8,762	50,601	15,040	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,107,382	287,861	11,226	717,048	88.00
88.01	08801	RURAL HEALTH CLINIC II	323,601	114,501	554	54,929	88.01
88.02	08802	RURAL HEALTH CLINIC III	887,596	54,851	9,444	150,170	88.02
90.00	09000	CLINIC	665,484	300,192	27,915	158,251	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	213,555	16,603	3,765	39,905	90.01
91.00	09100	EMERGENCY	1,439,534	211,387	44,376	186,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	579,799	9,909	1,718	101,027	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,016,119	3,306,665	1,840,206	4,111,865	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	15,414	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,374	0	352	1,177	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	192.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

 Period:
 From 05/01/2019
 To 04/30/2020

 Worksheet B
 Part I
 Date/Time Prepared:
 10/29/2020 9:00 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
194.00	07950	NONREIMBURSEABLE	-3,526	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	88,926	43,951	15,668	0	342	194.01
194.02	07952	FOUNDATION SERVICES	63,836	1,101	96	12,205	68	194.02
194.03	07953	WELLNESS	82,360	76,848	4,133	13,444	68	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	44,263,089	3,443,979	1,860,455	4,138,691	31,146	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,201,722					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	334,732				5.03
5.04	00570	ADMITTING	0	949	629,581			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,018,045	698	0	3,477,954		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,183,677	2,645	0	0	5,401,044	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,730	0	0	2,117,113	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,098	0	0	209,104	8.00
9.00	00900	HOUSEKEEPING	0	6,233	0	0	652,327	9.00
10.00	01000	DIETARY	0	21,903	0	0	516,393	10.00
11.00	01100	CAFETERIA	0	0	0	0	457,717	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	95	0	0	823,057	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	136,535	0	0	3,382,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	370	0	0	708,483	16.00
17.00	01700	SOCIAL SERVICE	0	41	0	0	77,930	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	7,118	173,526	177,024	3,266,987	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	2	23,303	23,772	118,055	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,066	0	0	1,406,230	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	15,910	106,282	604,660	3,266,144	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	35,104	41,022	230,148	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,309	48,459	692,709	2,587,924	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	11,267	120,659	357,358	54.01
60.00	06000	LABORATORY	0	23,897	65,410	634,953	2,490,943	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,728	5,661	10,202	201,815	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,737	19,017	65,985	789,629	65.00
66.00	06600	PHYSICAL THERAPY	0	1,213	35,244	179,788	1,955,950	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,942	31,019	50,877	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	52,331	13,102	51,188	669,360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,448	10,260	21,501	349,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	68,027	347,121	421,870	73.00
76.00	03950	CARDIAC REHAB	0	378	36	11,364	86,318	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	10,747	0	0	5,138,918	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,234	0	0	495,298	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,740	0	0	1,105,581	88.02
90.00	09000	CLINIC	0	5,511	996	97,871	1,259,780	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	292	0	13,334	287,454	90.01
91.00	09100	EMERGENCY	0	4,147	11,945	315,583	2,213,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1,440	0	38,199	732,708	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,201,722	332,545	629,581	3,477,954	43,829,065	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15,414	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	16,903	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	-3,526	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	1,687	0	0	150,574	194.01
194.02	07952	FOUNDATION SERVICES	0	22	0	0	77,328	194.02
194.03	07953	WELLNESS	0	478	0	0	177,331	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,201,722	334,732	629,581	3,477,954	44,263,089	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	5,401,044					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	294,209	0	2,411,322			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,059	0	46,774	284,937		8.00
9.00	00900	HOUSEKEEPING	90,652	0	15,254	0	758,233	9.00
10.00	01000	DIETARY	71,762	0	67,721	7,607	21,445	10.00
11.00	01100	CAFETERIA	63,608	0	36,218	3,855	11,469	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	114,378	0	12,490	0	3,955	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	470,091	0	23,360	0	7,397	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,456	0	57,257	0	18,132	16.00
17.00	01700	SOCIAL SERVICE	10,830	0	1,547	0	490	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	454,003	0	245,718	88,089	77,813	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	16,406	0	11,698	823	3,705	43.00
44.00	04400	SKILLED NURSING FACILITY	195,420	0	200,546	57,671	63,508	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	453,886	0	382,247	49,234	121,048	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,983	0	24,133	3,941	7,642	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	359,636	0	62,581	15,183	19,818	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	49,661	0	8,935	0	2,829	54.01
60.00	06000	LABORATORY	346,159	0	31,465	523	9,964	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	28,046	0	2,026	0	642	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	109,732	0	28,223	2,306	8,938	65.00
66.00	06600	PHYSICAL THERAPY	271,813	0	184,647	0	58,473	66.00
69.00	06900	ELECTROCARDIOLOGY	7,070	0	5,011	0	1,587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	93,019	0	13,798	0	4,370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,625	0	4,808	0	1,523	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,626	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	11,995	0	42,335	0	13,406	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	714,150	0	240,836	3,568	76,267	88.00
88.01	08801	RURAL HEALTH CLINIC II	68,830	0	95,796	84	30,336	88.01
88.02	08802	RURAL HEALTH CLINIC III	153,639	0	45,890	147	14,532	88.02
90.00	09000	CLINIC	175,068	0	251,152	2,627	79,534	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	39,947	0	13,890	0	4,399	90.01
91.00	09100	EMERGENCY	307,658	0	176,855	46,822	56,006	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	101,822	0	0	0	2,625	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,340,239	0	2,333,211	282,480	721,853	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,142	0	12,896	0	4,084	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,349	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	20,925	0	0	0	11,644	194.01
194.02	07952	FOUNDATION SERVICES	10,746	0	921	0	292	194.02
194.03	07953	WELLNESS	24,643	0	64,294	2,457	20,360	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	5,401,044	0	2,411,322	284,937	758,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	684,928					10.00
11.00	01100	CAFETERIA	0	572,867				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	19,419	0	973,299		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	19,419	0	64,840	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,274	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,427	0	8,430	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	274,989	101,953	0	352,752	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	356,040	48,548	0	164,917	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,895	33,984	0	117,524	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,282	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29,129	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	4,855	0	0	0	54.01
60.00	06000	LABORATORY	0	31,556	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	16,992	0	62,789	0	65.00
66.00	06600	PHYSICAL THERAPY	0	41,266	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	87,386	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	36,411	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	26,004	38,838	0	136,645	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	19,419	0	65,402	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	684,928	563,158	0	973,299	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION SERVICES	0	2,427	0	0	0	194.02
194.03	07953	WELLNESS	0	7,282	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	684,928	572,867	0	973,299	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,967,860					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	906,602				16.00
17.00	01700	SOCIAL SERVICE	0	0	101,654			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	46,656	68,108	0	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	6,265	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	30,496	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	159,362	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,812	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	182,599	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	31,801	0	0	0	54.01
60.00	06000	LABORATORY	0	167,346	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,689	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	17,391	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	47,384	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,175	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,491	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,667	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,967,860	91,486	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	2,995	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	25,795	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	3,514	0	0	0	90.01
91.00	09100	EMERGENCY	0	83,174	2,033	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	1,017	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,967,860	906,602	101,654	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION SERVICES	0	0	0	0	0	194.02
194.03	07953	WELLNESS	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	3,967,860	906,602	101,654	0		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	4,977,068	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	156,952	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	2,523,376	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,611,324	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	315,941	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,256,870	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	455,439	0	54.01
60.00	06000	LABORATORY	0	0	0	3,077,956	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	235,218	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,036,000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,559,533	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	72,720	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	794,038	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	410,529	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,539,842	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	157,049	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	6,261,125	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	690,344	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,319,789	0	88.02
90.00	09000	CLINIC	0	0	0	1,830,367	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	349,204	0	90.01
91.00	09100	EMERGENCY	0	0	0	3,087,926	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	922,993	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	43,641,603	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	34,536	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	19,252	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

 Period:
 From 05/01/2019
 To 04/30/2020

 Worksheet B
 Part I
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
194.00	07950	NONREIMBURSEABLE	0	0	0	-3,526	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	183,143	0	194.01
194.02	07952	FOUNDATION SERVICES	0	0	0	91,714	0	194.02
194.03	07953	WELLNESS	0	0	0	296,367	0	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	44,263,089	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	54.01
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	CARDIAC REHAB	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
90.00	09000	CLINIC	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.10	19201	PHYSICIAN HOSPITALIST	192.10
194.00	07950	NONREIMBURSEABLE	194.00
194.01	07951	PROFESSIONAL BUILDINGS	194.01
194.02	07952	FOUNDATION SERVICES	194.02
194.03	07953	WELLNESS	194.03
194.04	07954	RENTED SPACE	194.04
194.05	07955	LITIGATION COSTS	194.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	44,263,089	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,069	142	19,211	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	23	5.01
5.02	00550	DATA PROCESSING	0	17,021	719,221	736,242	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	48,685	810	49,495	5.03
5.04	00570	ADMITTING	0	16,096	1,449	17,545	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	26,622	3,286	29,908	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	199,364	7,190	206,554	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	181,110	68,565	249,675	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,907	3,041	58,948	8.00
9.00	00900	HOUSEKEEPING	0	18,232	662	18,894	9.00
10.00	01000	DIETARY	0	80,944	13,043	93,987	10.00
11.00	01100	CAFETERIA	0	43,290	0	43,290	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	14,929	0	14,929	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	27,921	91,814	119,735	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	68,437	10,478	78,915	16.00
17.00	01700	SOCIAL SERVICE	0	1,850	0	1,850	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,497	293,696	78,715	387,908	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	42.00
43.00	04300	NURSERY	0	13,982	0	13,982	43.00
44.00	04400	SKILLED NURSING FACILITY	10,516	239,704	24,933	275,153	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	50,155	456,881	323,679	830,715	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,846	0	28,846	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	74,800	330,079	404,879	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	10,679	2,245	12,924	54.01
60.00	06000	LABORATORY	0	37,609	13,401	51,010	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,422	0	2,422	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	33,734	29,647	63,381	65.00
66.00	06600	PHYSICAL THERAPY	0	220,701	3,768	224,469	66.00
69.00	06900	ELECTROCARDIOLOGY	0	5,989	0	5,989	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,493	0	16,493	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,747	0	5,747	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	50,601	15,040	65,641	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	287,861	11,226	299,087	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	114,501	554	115,055	88.01
88.02	08802	RURAL HEALTH CLINIC III	12,600	54,851	9,444	76,895	88.02
90.00	09000	CLINIC	0	300,192	27,915	328,107	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	16,603	3,765	20,368	90.01
91.00	09100	EMERGENCY	0	211,387	44,376	255,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	9,909	1,718	11,627	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,768	3,306,665	1,840,206	5,235,639	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,414	0	15,414	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,500	0	352	1,852	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
194.01	07951	PROFESSIONAL BUILDINGS	0	43,951	15,668	59,619	0	194.01
194.02	07952	FOUNDATION SERVICES	0	1,101	96	1,197	57	194.02
194.03	07953	WELLNESS	0	76,848	4,133	80,981	62	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	90,268	3,443,979	1,860,455	5,394,702	19,211	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	23					5.01
5.02	00550	DATA PROCESSING	1	736,487				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	49,649			5.03
5.04	00570	ADMITTING	1	0	141	18,133		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1	464,208	103	0	494,867	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1	272,279	392	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	405	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	311	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	924	0	0	9.00
10.00	01000	DIETARY	0	0	3,249	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	14	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1	0	20,254	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1	0	55	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	6	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6	0	1,056	4,995	25,190	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	671	3,383	43.00
44.00	04400	SKILLED NURSING FACILITY	1	0	455	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1	0	2,360	3,062	86,041	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,011	5,837	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1	0	936	1,396	98,537	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	325	17,169	54.01
60.00	06000	LABORATORY	0	0	3,544	1,884	90,351	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	850	163	1,452	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	554	548	9,389	65.00
66.00	06600	PHYSICAL THERAPY	0	0	180	1,015	25,583	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	56	4,414	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	7,761	377	7,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,995	296	3,060	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,960	49,394	73.00
76.00	03950	CARDIAC REHAB	0	0	56	1	1,617	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3	0	1,594	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	183	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1	0	258	0	0	88.02
90.00	09000	CLINIC	3	0	817	29	13,927	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	43	0	1,897	90.01
91.00	09100	EMERGENCY	1	0	615	344	44,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	214	0	5,436	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23	736,487	49,325	18,133	494,867	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	250	0	0	194.01
194.02	07952	FOUNDATION SERVICES	0	0	3	0	0	194.02
194.03	07953	WELLNESS	0	0	71	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	
		5.01	5.02	5.03	5.04	5.05	
194.04	07954 RENTED SPACE	0	0	0	0	0	194.04
194.05	07955 LITIGATION COSTS	0	0	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	23	736,487	49,649	18,133	494,867	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	480,593					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	26,180	0	276,683			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,586	0	5,367	67,294		8.00
9.00	00900	HOUSEKEEPING	8,067	0	1,750	0	29,995	9.00
10.00	01000	DIETARY	6,386	0	7,770	1,797	848	10.00
11.00	01100	CAFETERIA	5,660	0	4,156	910	454	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	10,178	0	1,433	0	156	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	41,831	0	2,680	0	293	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,761	0	6,570	0	717	16.00
17.00	01700	SOCIAL SERVICE	964	0	178	0	19	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,400	0	28,194	20,803	3,078	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,460	0	1,342	194	147	43.00
44.00	04400	SKILLED NURSING FACILITY	17,389	0	23,011	13,620	2,512	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	40,389	0	43,861	11,628	4,789	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,846	0	2,769	931	302	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,002	0	7,181	3,586	784	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	4,419	0	1,025	0	112	54.01
60.00	06000	LABORATORY	30,803	0	3,610	124	394	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,496	0	233	0	25	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	9,765	0	3,238	545	354	65.00
66.00	06600	PHYSICAL THERAPY	24,187	0	21,187	0	2,313	66.00
69.00	06900	ELECTROCARDIOLOGY	629	0	575	0	63	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,277	0	1,583	0	173	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,327	0	552	0	60	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,217	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	1,067	0	4,858	0	530	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	63,528	0	27,634	843	3,017	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,125	0	10,992	20	1,200	88.01
88.02	08802	RURAL HEALTH CLINIC III	13,672	0	5,266	35	575	88.02
90.00	09000	CLINIC	15,578	0	28,818	620	3,146	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	3,555	0	1,594	0	174	90.01
91.00	09100	EMERGENCY	27,377	0	20,293	11,058	2,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	9,061	0	0	0	104	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	475,182	0	267,720	66,714	28,555	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	191	0	1,480	0	162	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	209	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	1,862	0	0	0	461	194.01
194.02	07952	FOUNDATION SERVICES	956	0	106	0	12	194.02
194.03	07953	WELLNESS	2,193	0	7,377	580	805	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	480,593	0	276,683	67,294	29,995	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	114,228					10.00
11.00	01100	CAFETERIA	0	54,754				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,856	0	29,168		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,856	0	1,943	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,320	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	232	0	253	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	45,861	9,746	0	10,571	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	59,378	4,640	0	4,942	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,652	3,248	0	3,522	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	696	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,784	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	464	0	0	0	54.01
60.00	06000	LABORATORY	0	3,016	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,624	0	1,882	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,944	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	8,352	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	3,480	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,337	3,712	0	4,095	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1,856	0	1,960	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,228	53,826	0	29,168	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION SERVICES	0	232	0	0	0	194.02
194.03	07953	WELLNESS	0	696	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	114,228	54,754	0	29,168	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	189,203					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	97,700				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,558			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	5,027	2,384			30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0			42.00
43.00	04300	NURSERY	0	675	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,067			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	17,170	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,165	0			52.00
53.00	05300	ANESTHESIOLOGY	0	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,691	0			54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	3,426	0			54.01
60.00	06000	LABORATORY	0	18,031	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	290	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	1,874	0			65.00
66.00	06600	PHYSICAL THERAPY	0	5,105	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	881	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,454	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	611	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	189,203	9,857	0			73.00
76.00	03950	CARDIAC REHAB	0	323	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0			88.02
90.00	09000	CLINIC	0	2,779	0			90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	379	0			90.01
91.00	09100	EMERGENCY	0	8,962	71			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	36			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	189,203	97,700	3,558	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0			192.10
194.00	07950	NONREIMBURSEABLE	0	0	0			194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0			194.01
194.02	07952	FOUNDATION SERVICES	0	0	0			194.02
194.03	07953	WELLNESS	0	0	0			194.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Date/Time Prepared:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
194.04	07954	RENTED SPACE	0	0	0			194.04
194.05	07955	LITIGATION COSTS	0	0	0			194.05
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	189,203	97,700	3,558	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				587,046	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)				0	0	42.00
43.00	04300	NURSERY				21,901	0	43.00
44.00	04400	SKILLED NURSING FACILITY				402,943	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				1,052,494	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				44,491	0	52.00
53.00	05300	ANESTHESIOLOGY				0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				572,467	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND				40,004	0	54.01
60.00	06000	LABORATORY				203,402	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				7,931	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				93,561	0	65.00
66.00	06600	PHYSICAL THERAPY				309,012	0	66.00
69.00	06900	ELECTROCARDIOLOGY				12,615	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				43,402	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				16,648	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				255,631	0	73.00
76.00	03950	CARDIAC REHAB				74,093	0	76.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				407,389	0	88.00
88.01	08801	RURAL HEALTH CLINIC II				133,830	0	88.01
88.02	08802	RURAL HEALTH CLINIC III				97,399	0	88.02
90.00	09000	CLINIC				398,038	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC				28,195	0	90.01
91.00	09100	EMERGENCY				384,614	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY				30,763	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	5,217,869	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				17,247	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				2,066	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST				0	0	192.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
194.00	07950	NONREIMBURSEABLE				0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS				62,192	0	194.01
194.02	07952	FOUNDATION SERVICES				2,563	0	194.02
194.03	07953	WELLNESS				92,765	0	194.03
194.04	07954	RENTED SPACE				0	0	194.04
194.05	07955	LITIGATION COSTS				0	0	194.05
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	5,394,702	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMITTING	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	54.01
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	CARDIAC REHAB	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
90.00	09000	CLINIC	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.10	19201	PHYSICIAN HOSPITALIST	192.10
194.00	07950	NONREIMBURSEABLE	194.00
194.01	07951	PROFESSIONAL BUILDINGS	194.01
194.02	07952	FOUNDATION SERVICES	194.02
194.03	07953	WELLNESS	194.03
194.04	07954	RENTED SPACE	194.04
194.05	07955	LITIGATION COSTS	194.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	5,394,702	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (MACHINE TIME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE NEW)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	156,406					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,985,322				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	866	151	19,965,912			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	23,509	455		5.01
5.02	00550	DATA PROCESSING	773	767,495	254,020	24	10,000	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	2,211	864	160,173	6	0	5.03
5.04	00570	ADMITTING	731	1,546	463,548	12	0	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,209	3,507	672,417	10	6,303	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	9,054	7,673	1,421,111	18	3,697	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	8,225	73,167	440,186	8	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,539	3,245	84,901	1	0	8.00
9.00	00900	HOUSEKEEPING	828	706	374,538	1	0	9.00
10.00	01000	DIETARY	3,676	13,918	198,274	7	0	10.00
11.00	01100	CAFETERIA	1,966	0	295,450	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	678	0	625,760	6	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,268	97,976	634,284	10	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,108	11,181	375,451	16	0	16.00
17.00	01700	SOCIAL SERVICE	84	0	58,503	2	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,338	83,998	1,898,806	55	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	635	0	48,364	2	0	43.00
44.00	04400	SKILLED NURSING FACILITY	10,886	26,606	805,942	28	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,749	345,403	1,097,990	26	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,310	0	91,265	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,397	352,233	717,580	17	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	485	2,396	145,125	0	0	54.01
60.00	06000	LABORATORY	1,708	14,300	659,607	8	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	110	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,532	31,637	422,629	6	0	65.00
66.00	06600	PHYSICAL THERAPY	10,023	4,021	1,069,421	7	0	66.00
69.00	06900	ELECTROCARDIOLOGY	272	0	7,910	2	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	749	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	261	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	2,298	16,049	0	2	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	13,073	11,979	3,459,186	68	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,200	591	264,991	7	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,491	10,078	724,452	26	0	88.02
90.00	09000	CLINIC	13,633	29,789	763,435	52	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	754	4,018	192,512	0	0	90.01
91.00	09100	EMERGENCY	9,600	47,354	897,776	12	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	450	1,833	487,376	9	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	150,170	1,963,714	19,836,492	448	10,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	700	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	376	5,680	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)	NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (MACHINE TIME)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE NEW)				
			1.00	2.00	4.00	5.01	5.02	
194.01	07951	PROFESSIONAL BUILDINGS	1,996	16,720	0	5	0	194.01
194.02	07952	FOUNDATION SERVICES	50	102	58,881	1	0	194.02
194.03	07953	WELLNESS	3,490	4,410	64,859	1	0	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	3,443,979	1,860,455	4,138,691	31,146	3,201,722	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.019481	0.937105	0.207288	68.452747	320.172200	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			19,211	23	736,487	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000962	0.050549	73.648700	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: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			PURCHASING RECEIVING AND STORES (COST REQ'S)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5,195,317					5.03
5.04	00570	ADMITTING	14,726	14,326,929				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	10,827	0	77,583,215			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	41,053	0	0	-5,401,044	38,865,571	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	42,372	0	0	0	2,117,113	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	32,566	0	0	0	209,104	8.00
9.00	00900	HOUSEKEEPING	96,733	0	0	0	652,327	9.00
10.00	01000	DIETARY	339,956	0	0	0	516,393	10.00
11.00	01100	CAFETERIA	0	0	0	0	457,717	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,473	0	0	0	823,057	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	2,119,135	0	0	0	3,382,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,749	0	0	0	708,483	16.00
17.00	01700	SOCIAL SERVICE	643	0	0	0	77,930	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	110,474	3,948,870	3,948,870	0	3,266,987	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	28	530,287	530,287	0	118,055	43.00
44.00	04400	SKILLED NURSING FACILITY	47,584	0	0	0	1,406,230	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	246,939	2,418,570	13,488,137	0	3,266,144	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	798,825	915,087	0	230,148	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	97,927	1,102,734	15,452,777	0	2,587,924	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	4	256,395	2,691,549	0	357,358	54.01
60.00	06000	LABORATORY	370,903	1,488,481	14,163,897	0	2,490,943	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	88,901	128,823	227,585	0	201,815	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	58,008	432,747	1,471,918	0	789,629	65.00
66.00	06600	PHYSICAL THERAPY	18,825	802,018	4,010,526	0	1,955,950	66.00
69.00	06900	ELECTROCARDIOLOGY	0	44,193	691,935	0	50,877	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	812,211	298,143	1,141,855	0	669,360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	208,728	233,488	479,623	0	349,906	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,548,044	7,743,221	0	421,870	73.00
76.00	03950	CARDIAC REHAB	5,874	825	253,500	0	86,318	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	166,796	0	0	0	5,138,918	88.00
88.01	08801	RURAL HEALTH CLINIC II	19,160	0	0	0	495,298	88.01
88.02	08802	RURAL HEALTH CLINIC III	26,999	0	0	0	1,105,581	88.02
90.00	09000	CLINIC	85,531	22,668	2,183,208	0	1,259,780	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	4,537	0	297,446	0	287,454	90.01
91.00	09100	EMERGENCY	64,358	271,818	7,039,697	0	2,213,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	22,349	0	852,097	0	732,708	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,161,369	14,326,929	77,583,215	-5,401,044	38,428,021	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	15,414	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	16,903	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	3,526	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	26,182	0	0	0	150,574	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			PURCHASING RECEIVING AND STORES (COST REQ'S)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	
			5.03	5.04	5.05	5A.06	5.06	
194.02	07952	FOUNDATION SERVICES	347	0	0	0	77,328	194.02
194.03	07953	WELLNESS	7,419	0	0	0	177,331	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	334,732	629,581	3,477,954		5,401,044	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.064430	0.043944	0.044829		0.138967	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	49,649	18,133	494,867		480,593	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009556	0.001266	0.006379		0.012366	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: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	130,891				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,539	145,328			8.00
9.00	00900	HOUSEKEEPING	0	828	0	129,970		9.00
10.00	01000	DIETARY	0	3,676	3,880	3,676	35,137	10.00
11.00	01100	CAFETERIA	0	1,966	1,966	1,966	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	678	0	678	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,268	0	1,268	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,108	0	3,108	0	16.00
17.00	01700	SOCIAL SERVICE	0	84	0	84	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	13,338	44,928	13,338	14,107	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	635	420	635	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	10,886	29,414	10,886	18,265	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,749	25,111	20,749	1,431	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,310	2,010	1,310	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,397	7,744	3,397	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	485	0	485	0	54.01
60.00	06000	LABORATORY	0	1,708	267	1,708	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	110	0	110	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,532	1,176	1,532	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,023	0	10,023	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	272	0	272	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	749	0	749	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	261	0	261	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	2,298	0	2,298	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	13,073	1,820	13,073	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,200	43	5,200	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,491	75	2,491	0	88.02
90.00	09000	CLINIC	0	13,633	1,340	13,633	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	754	0	754	0	90.01
91.00	09100	EMERGENCY	0	9,600	23,881	9,600	1,334	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	450	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	126,651	144,075	123,734	35,137	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	700	0	700	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	1,996	0	194.01
194.02	07952	FOUNDATION SERVICES	0	50	0	50	0	194.02
194.03	07953	WELLNESS	0	3,490	1,253	3,490	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS)	
			6.00	7.00	8.00	9.00	10.00	
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	2,411,322	284,937	758,233	684,928	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	18.422367	1.960648	5.833908	19.493070	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	276,683	67,294	29,995	114,228	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.113843	0.463049	0.230784	3.250932	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: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (CSS CSTED REQ')	PHARMACY (RX CSTD REQ'S)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	236					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	8	0	240,609			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	8	0	16,029	0	629,031	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1	0	2,084	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42	0	87,204	0	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	20	0	40,769	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14	0	29,053	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2	0	0	0	0	54.01
60.00	06000	LABORATORY	13	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	7	0	15,522	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	629,031	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	36	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	15	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	16	0	33,780	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	8	0	16,168	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	232	0	240,609	0	629,031	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (CSS CSTED REQ')	PHARMACY (RX CSTD REQ'S)	
			11.00	12.00	13.00	14.00	15.00	
194.02	07952	FOUNDATION SERVICES	1	0	0	0	0	194.02
194.03	07953	WELLNESS	3	0	0	0	0	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	572,867	0	973,299	0	3,967,860	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,427.402542	0.000000	4.045148	0.000000	6.307893	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	54,754	0	29,168	0	189,203	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	232.008475	0.000000	0.121226	0.000000	0.300785	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: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	76,731,118					16.00
17.00	01700	SOCIAL SERVICE	0	100				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,948,870	67	0	0	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	0	0	0	42.00
43.00	04300	NURSERY	530,287	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	30	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,488,137	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	915,087	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,452,777	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2,691,549	0	0	0	0	54.01
60.00	06000	LABORATORY	14,163,897	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	227,585	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,471,918	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,010,526	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	691,935	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,141,855	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	479,623	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,743,221	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	253,500	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	2,183,208	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	297,446	0	0	0	0	90.01
91.00	09100	EMERGENCY	7,039,697	2	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,731,118	100	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	0	0	0	192.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
194.00	07950	NONREIMBURSEABLE	0	0	0	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	0	0	0	194.01
194.02	07952	FOUNDATION SERVICES	0	0	0	0	0	194.02
194.03	07953	WELLNESS	0	0	0	0	0	194.03
194.04	07954	RENTED SPACE	0	0	0	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	0	0	0	194.05
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)	906,602	101,654	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011815	1,016.540000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	97,700	3,558	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001273	35.580000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet B-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING RECEIVING AND STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL			5.06
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	54.01
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.10	19201	PHYSICIAN HOSPITALIST	0	0	192.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet B-1
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
194.00	07950	NONREIMBURSEABLE	0	0	194.00
194.01	07951	PROFESSIONAL BUILDINGS	0	0	194.01
194.02	07952	FOUNDATION SERVICES	0	0	194.02
194.03	07953	WELLNESS	0	0	194.03
194.04	07954	RENTED SPACE	0	0	194.04
194.05	07955	LITIGATION COSTS	0	0	194.05
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
10/29/2020 9:00 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,977,068		4,977,068	0	4,977,068	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0		0	0	0	42.00
43.00	04300	NURSERY	156,952		156,952	0	156,952	43.00
44.00	04400	SKILLED NURSING FACILITY	2,523,376		2,523,376	0	2,523,376	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,611,324		4,611,324	0	4,611,324	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	315,941		315,941	0	315,941	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,256,870		3,256,870	0	3,256,870	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	455,439		455,439	0	455,439	54.01
60.00	06000	LABORATORY	3,077,956		3,077,956	0	3,077,956	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	235,218		235,218	0	235,218	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,036,000	0	1,036,000	0	1,036,000	65.00
66.00	06600	PHYSICAL THERAPY	2,559,533	0	2,559,533	0	2,559,533	66.00
69.00	06900	ELECTROCARDIOLOGY	72,720		72,720	0	72,720	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	794,038		794,038	0	794,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,529		410,529	0	410,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,539,842		4,539,842	0	4,539,842	73.00
76.00	03950	CARDIAC REHAB	157,049		157,049	0	157,049	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,261,125		6,261,125	0	6,261,125	88.00
88.01	08801	RURAL HEALTH CLINIC II	690,344		690,344	0	690,344	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,319,789		1,319,789	0	1,319,789	88.02
90.00	09000	CLINIC	1,830,367		1,830,367	0	1,830,367	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	349,204		349,204	0	349,204	90.01
91.00	09100	EMERGENCY	3,087,926		3,087,926	0	3,087,926	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	565,935		565,935	0	565,935	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	922,993		922,993		922,993	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	44,207,538	0	44,207,538	0	44,207,538	200.00
201.00		Less Observation Beds	565,935		565,935		565,935	201.00
202.00		Total (see instructions)	43,641,603	0	43,641,603	0	43,641,603	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
10/29/2020 9:00 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,756,202		3,756,202		30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0		0		42.00
43.00	04300	NURSERY	530,287		530,287		43.00
44.00	04400	SKILLED NURSING FACILITY	845,031		845,031		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,418,570	11,069,567	13,488,137	0.341880	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	798,825	116,262	915,087	0.345258	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,102,734	14,350,043	15,452,777	0.210763	0.000000
54.01	05401	RADIOLOGY-ULTRASOUND	256,395	2,435,154	2,691,549	0.169211	0.000000
60.00	06000	LABORATORY	1,488,481	12,675,416	14,163,897	0.217310	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	338,878	205,430	544,308	0.432141	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	432,747	1,039,171	1,471,918	0.703844	0.000000
66.00	06600	PHYSICAL THERAPY	802,018	3,208,508	4,010,526	0.638204	0.000000
69.00	06900	ELECTROCARDIOLOGY	44,193	647,742	691,935	0.105097	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	298,143	843,712	1,141,855	0.695393	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	233,488	246,135	479,623	0.855941	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,548,044	6,195,177	7,743,221	0.586299	0.000000
76.00	03950	CARDIAC REHAB	0	253,500	253,500	0.619523	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,866,000	5,866,000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	483,490	483,490		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,193,180	1,193,180		88.02
90.00	09000	CLINIC	22,668	2,160,540	2,183,208	0.838384	0.000000
90.01	09001	PAIN MANAGEMENT CLINIC	0	297,446	297,446	1.174008	0.000000
91.00	09100	EMERGENCY	271,818	6,767,879	7,039,697	0.438645	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	9,750	600,842	610,592	0.926863	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	852,097	852,097		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,198,272	71,507,291	86,705,563		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,198,272	71,507,291	86,705,563		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
42.00	04200	SUBPROVIDER (SPECIFY)				42.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.341880			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.345258			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210763			54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.169211			54.01
60.00	06000	LABORATORY	0.217310			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.432141			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.703844			65.00
66.00	06600	PHYSICAL THERAPY	0.638204			66.00
69.00	06900	ELECTROCARDIOLOGY	0.105097			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.695393			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.855941			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.586299			73.00
76.00	03950	CARDIAC REHAB	0.619523			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
90.00	09000	CLINIC	0.838384			90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1.174008			90.01
91.00	09100	EMERGENCY	0.438645			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.926863			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
10/29/2020 9:00 am

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,977,068		4,977,068	0	4,977,068	30.00
42.00	04200	SUBPROVIDER (SPECIFY)	0		0	0	0	42.00
43.00	04300	NURSERY	156,952		156,952	0	156,952	43.00
44.00	04400	SKILLED NURSING FACILITY	2,523,376		2,523,376	0	2,523,376	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,611,324		4,611,324	0	4,611,324	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	315,941		315,941	0	315,941	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,256,870		3,256,870	0	3,256,870	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	455,439		455,439	0	455,439	54.01
60.00	06000	LABORATORY	3,077,956		3,077,956	0	3,077,956	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	235,218		235,218	0	235,218	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,036,000	0	1,036,000	0	1,036,000	65.00
66.00	06600	PHYSICAL THERAPY	2,559,533	172	2,559,705	0	2,559,705	66.00
69.00	06900	ELECTROCARDIOLOGY	72,720		72,720	0	72,720	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	794,038		794,038	0	794,038	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,529		410,529	0	410,529	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,539,842		4,539,842	0	4,539,842	73.00
76.00	03950	CARDIAC REHAB	157,049		157,049	0	157,049	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,261,125		6,261,125	0	6,261,125	88.00
88.01	08801	RURAL HEALTH CLINIC II	690,344		690,344	0	690,344	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,319,789		1,319,789	0	1,319,789	88.02
90.00	09000	CLINIC	1,830,367		1,830,367	0	1,830,367	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	349,204		349,204	0	349,204	90.01
91.00	09100	EMERGENCY	3,087,926		3,087,926	0	3,087,926	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	565,927		565,927	0	565,927	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	922,993		922,993		922,993	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	44,207,530	0	44,207,702	0	44,207,702	200.00
201.00		Less Observation Beds	565,927		565,927		565,927	201.00
202.00		Total (see instructions)	43,641,603	0	43,641,775	0	43,641,775	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
10/29/2020 9:00 am

			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
42.00	04200	SUBPROVIDER (SPECIFY)	0		0			42.00	
43.00	04300	NURSERY	0		0			43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0.000000	0.000000	54.00	
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0.000000	0.000000	54.01	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0		0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0		0	0.000000	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
76.00	03950	CARDIAC REHAB	0	0	0	0.000000	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0		0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000	88.02	
90.00	09000	CLINIC	0		0	0.000000	0.000000	90.00	
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0.000000	0.000000	90.01	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part I
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
42.00	04200	SUBPROVIDER (SPECIFY)				42.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000			54.01
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950	CARDIAC REHAB	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			88.02
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.000000			90.01
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part II
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,611,324	1,052,494	3,558,830	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	315,941	44,491	271,450	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,256,870	572,467	2,684,403	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	455,439	40,004	415,435	0	0	54.01
60.00	06000	LABORATORY	3,077,956	203,402	2,874,554	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	235,218	7,931	227,287	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,036,000	93,561	942,439	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,559,533	309,012	2,250,521	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	72,720	12,615	60,105	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	794,038	43,402	750,636	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,529	16,648	393,881	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,539,842	255,631	4,284,211	0	0	73.00
76.00	03950	CARDIAC REHAB	157,049	74,093	82,956	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,261,125	407,389	5,853,736	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	690,344	133,830	556,514	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,319,789	97,399	1,222,390	0	0	88.02
90.00	09000	CLINIC	1,830,367	398,038	1,432,329	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	349,204	28,195	321,009	0	0	90.01
91.00	09100	EMERGENCY	3,087,926	384,614	2,703,312	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	565,927	66,751	499,176	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	922,993	30,763	892,230	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	36,550,134	4,272,730	32,277,404	0	0	200.00
201.00		Less Observation Beds	565,927	66,751	499,176	0	0	201.00
202.00		Total (line 200 minus line 201)	35,984,207	4,205,979	31,778,228	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet C
Part II
Date/Time Prepared:
10/29/2020 9:00 am

				Title XIX		Hospital	PPS	
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)			
		6.00						7.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,611,324	13,488,137	0.341880		50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	315,941	915,087	0.345258		52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,256,870	15,452,777	0.210763		54.00	
54.01	05401	RADIOLOGY-ULTRASOUND	455,439	2,691,549	0.169211		54.01	
60.00	06000	LABORATORY	3,077,956	14,163,897	0.217310		60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	235,218	544,308	0.432141		62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30	
65.00	06500	RESPIRATORY THERAPY	1,036,000	1,471,918	0.703844		65.00	
66.00	06600	PHYSICAL THERAPY	2,559,533	4,010,526	0.638204		66.00	
69.00	06900	ELECTROCARDIOLOGY	72,720	691,935	0.105097		69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	794,038	1,141,855	0.695393		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	410,529	479,623	0.855941		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,539,842	7,743,221	0.586299		73.00	
76.00	03950	CARDIAC REHAB	157,049	253,500	0.619523		76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000		76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000		76.99	
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,261,125	5,866,000	1.067359		88.00	
88.01	08801	RURAL HEALTH CLINIC II	690,344	483,490	1.427835		88.01	
88.02	08802	RURAL HEALTH CLINIC III	1,319,789	1,193,180	1.106111		88.02	
90.00	09000	CLINIC	1,830,367	2,183,208	0.838384		90.00	
90.01	09001	PAIN MANAGEMENT CLINIC	349,204	297,446	1.174008		90.01	
91.00	09100	EMERGENCY	3,087,926	7,039,697	0.438645		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	565,927	610,592	0.926850		92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000		93.99	
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	922,993	852,097	1.083202		101.00	
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00	
200.00		Subtotal (sum of lines 50 thru 199)	36,550,134	81,574,043			200.00	
201.00		Less Observation Beds	565,927	0			201.00	
202.00		Total (line 200 minus line 201)	35,984,207	81,574,043			202.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
10/29/2020 9:00 am

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	1,052,494	13,488,137	0.078031	797,758	62,250	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,491	915,087	0.048619	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,467	15,452,777	0.037046	627,302	23,239	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	40,004	2,691,549	0.014863	45,782	680	54.01
60.00	06000	LABORATORY	203,402	14,163,897	0.014361	617,185	8,863	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,931	544,308	0.014571	139,121	2,027	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	93,561	1,471,918	0.063564	175,386	11,148	65.00
66.00	06600	PHYSICAL THERAPY	309,012	4,010,526	0.077050	110,649	8,526	66.00
69.00	06900	ELECTROCARDIOLOGY	12,615	691,935	0.018231	22,556	411	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,402	1,141,855	0.038010	113,746	4,323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,648	479,623	0.034711	149,476	5,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255,631	7,743,221	0.033014	571,507	18,868	73.00
76.00	03950	CARDIAC REHAB	74,093	253,500	0.292280	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	407,389	5,866,000	0.069449	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	133,830	483,490	0.276800	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	97,399	1,193,180	0.081630	0	0	88.02
90.00	09000	CLINIC	398,038	2,183,208	0.182318	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	28,195	297,446	0.094790	0	0	90.01
91.00	09100	EMERGENCY	384,614	7,039,697	0.054635	120,618	6,590	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	66,752	610,592	0.109323	9,274	1,014	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	4,241,968	80,721,946		3,500,360	153,127	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet D
Part IV
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1343		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 10/29/2020 9:00 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	13,488,137	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	915,087	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,452,777	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	2,691,549	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	14,163,897	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	544,308	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,471,918	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,010,526	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	691,935	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,141,855	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	479,623	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,743,221	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	253,500	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,866,000	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	483,490	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	1,193,180	0.000000	88.02
90.00	09000	CLINIC	0	0	0	2,183,208	0.000000	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	297,446	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	7,039,697	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	610,592	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	80,721,946		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	797,758	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	627,302	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	45,782	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	617,185	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	139,121	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	175,386	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	110,649	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	22,556	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	113,746	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	149,476	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	571,507	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	120,618	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	9,274	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		3,500,360	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
10/29/2020 9:00 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.341880	0	3,408,243	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.345258	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210763	0	5,630,003	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.169211	0	454,757	0	0	54.01
60.00	06000	LABORATORY	0.217310	0	5,821,595	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.432141	0	122,833	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.703844	0	201,776	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.638204	0	987,562	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.105097	0	581,854	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.695393	0	197,498	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.855941	0	109,283	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.586299	0	2,683,666	0	0	73.00
76.00	03950	CARDIAC REHAB	0.619523	0	91,292	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	0.838384	0	957,804	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1.174008	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.438645	0	2,225,495	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.926863	0	298,199	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	23,771,860	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	23,771,860	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part V
Date/Time Prepared:
10/29/2020 9:00 am

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
			ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,165,210	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,186,596	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	76,950	0		54.01
60.00	06000	LABORATORY	1,265,091	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	53,081	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	142,019	0		65.00
66.00	06600	PHYSICAL THERAPY	630,266	0		66.00
69.00	06900	ELECTROCARDIOLOGY	61,151	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	137,339	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	93,540	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,573,431	0		73.00
76.00	03950	CARDIAC REHAB	56,557	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	803,008	0		90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0		90.01
91.00	09100	EMERGENCY	976,202	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	276,390	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	8,496,831	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	8,496,831	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part I
Date/Time Prepared:
10/29/2020 9:00 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	587,046	160,533	426,513	2,460	173.38	30.00
42.00	SUBPROVIDER (SPECIFY)	0	0	0	0	0.00	42.00
43.00	NURSERY	21,901		21,901	281	77.94	43.00
44.00	SKILLED NURSING FACILITY	402,943		402,943	4,782	84.26	44.00
200.00	Total (lines 30 through 199)	1,011,890		851,357	7,523		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	36	6,242				30.00
42.00	SUBPROVIDER (SPECIFY)	0	0				42.00
43.00	NURSERY	68	5,300				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	104	11,542				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part II
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Title XIX		Hospital		PPS	
		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	1,052,494	0	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,491	0	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,467	0	0.000000	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	40,004	0	0.000000	0	54.01
60.00	06000	LABORATORY	203,402	0	0.000000	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,931	0	0.000000	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	93,561	0	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	309,012	0	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	12,615	0	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,402	0	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,648	0	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255,631	0	0.000000	0	73.00
76.00	03950	CARDIAC REHAB	74,093	0	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	407,389	0	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	133,830	0	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	97,399	0	0.000000	0	88.02
90.00	09000	CLINIC	398,038	0	0.000000	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	28,195	0	0.000000	0	90.01
91.00	09100	EMERGENCY	384,614	0	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	66,751	0	0.000000	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	93.99
200.00		Total (lines 50 through 199)	4,241,967	0		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1343		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part III Date/Time Prepared: 10/29/2020 9:00 am	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)		0	0	0	0	0	0	42.00
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	2,460	0.00		36	30.00
42.00	04200	SUBPROVIDER (SPECIFY)		0	0	0	0.00		0	42.00
43.00	04300	NURSERY		0	0	281	0.00		68	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	4,782	0.00		0	44.00
200.00		Total (lines 30 through 199)		0	0	7,523			104	200.00
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
42.00	04200	SUBPROVIDER (SPECIFY)		0						42.00
43.00	04300	NURSERY		0						43.00
44.00	04400	SKILLED NURSING FACILITY		0						44.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet D
Part IV
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Title XIX		Hospital		PPS	
		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1343		Period: From 05/01/2019 To 04/30/2020		Worksheet D Part IV Date/Time Prepared: 10/29/2020 9:00 am	
			Title XIX		Hospital		PPS	
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	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0.000000	54.01
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.00	03950	CARDIAC REHAB	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet D
Part IV
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Title XIX			Hospital		PPS
		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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	0	0	0	54.01
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.000000	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 10/29/2020 9:00 am
		Title XVIII	Hospital	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,430	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,460	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)		2,075	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		614	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)		307	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		33	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)		16	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,012	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)		569	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)		284	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		144.67	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,977,068	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)		4,774	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		2,360	25.00
26.00	Total swing-bed cost (see instructions)		1,360,967	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,616,101	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,616,101	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)		1,469.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,487,600	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,487,600	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
10/29/2020 9:00 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	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)					1,406,988 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,894,588 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)					836,407 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					417,469 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,253,876 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)					385 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,469.96 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					565,935 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
10/29/2020 9:00 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	587,046	4,977,068	0.117950	565,935	66,752
91.00	Nursing School cost	0	4,977,068	0.000000	565,935	0
92.00	Allied health cost	0	4,977,068	0.000000	565,935	0
93.00	All other Medical Education	0	4,977,068	0.000000	565,935	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1343 Component CCN: 14-6150	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 10/29/2020 9:00 am
		Title XVIII	Skilled Nursing Facility	PPS
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)		4,782	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,782	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)		4,782	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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		0	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)		1,038	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	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)		2,523,376	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)		0	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)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,523,376	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)		2,523,376	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1343 Component CCN: 14-6150	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 10/29/2020 9:00 am
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					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)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
56.00 Target amount (line 54 x line 55)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 Bonus payment (see instructions)					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					59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					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)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					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)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					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)					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)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					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)				2,523,376	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				527.68	71.00
72.00 Program routine service cost (line 9 x line 71)				547,732	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)				0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)				547,732	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)				0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)				0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)				0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)				0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0	80.00
81.00 Inpatient routine service cost per diem limitation				0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)				0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)				547,732	83.00
84.00 Program inpatient ancillary services (see instructions)				247,341	84.00
85.00 Utilization review - physician compensation (see instructions)				0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				795,073	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)				0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1343 Component CCN: 14-6150		Period: From 05/01/2019 To 04/30/2020		Worksheet D-1 Date/Time Prepared: 10/29/2020 9:00 am
			Title XVIII		Skilled Nursing Facility		PPS
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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 10/29/2020 9:00 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,430	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,460	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)		2,075	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		356	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)		565	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7	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)		42	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		36	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		281	15.00
16.00	Nursery days (title V or XIX only)		68	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		144.67	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		147.52	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,977,068	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)		1,013	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)		6,196	25.00
26.00	Total swing-bed cost (see instructions)		1,361,024	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,616,044	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,616,044	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)		1,469.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		52,918	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)		52,918	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet D-1 Date/Time Prepared: 10/29/2020 9:00 am	
			Title XIX	Hospital	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	156,952	281	558.55	68	37,981	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					90,899	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)					11,542	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)					11,542	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					79,357	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					385	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,469.94	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					565,927	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet D-1

Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Title XIX		Hospital	PPS	
		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	587,046	4,977,068	0.117950	565,927	66,751 90.00
91.00	Nursing School cost	0	4,977,068	0.000000	565,927	0 91.00
92.00	Allied health cost	0	4,977,068	0.000000	565,927	0 92.00
93.00	All other Medical Education	0	4,977,068	0.000000	565,927	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 10/29/2020 9:00 am
			Title XVIII	Hospital	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,494,788	30.00
42.00	04200	SUBPROVIDER (SPECIFY)		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.341880	797,758	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.345258	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210763	627,302	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.169211	45,782	54.01
60.00	06000	LABORATORY	0.217310	617,185	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.432141	139,121	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.703844	175,386	65.00
66.00	06600	PHYSICAL THERAPY	0.638204	110,649	66.00
69.00	06900	ELECTROCARDIOLOGY	0.105097	22,556	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.695393	113,746	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.855941	149,476	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.586299	571,507	73.00
76.00	03950	CARDIAC REHAB	0.619523	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
90.00	09000	CLINIC	0.838384	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	1.174008	0	90.01
91.00	09100	EMERGENCY	0.438645	120,618	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.926863	9,274	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,500,360	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)		3,500,360	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3
			Component CCN: 14-Z343		Date/Time Prepared: 10/29/2020 9:00 am
			Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.341880	3,759	1,285
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.345258	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210763	20,838	4,392
54.01	05401	RADIOLOGY-ULTRASOUND	0.169211	1,518	257
60.00	06000	LABORATORY	0.217310	85,944	18,676
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.432141	8,266	3,572
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	0.703844	32,251	22,700
66.00	06600	PHYSICAL THERAPY	0.638204	162,359	103,618
69.00	06900	ELECTROCARDIOLOGY	0.105097	3,707	390
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.695393	45,851	31,884
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.855941	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.586299	183,424	107,541
76.00	03950	CARDIAC REHAB	0.619523	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0
76.99	07699	LITHOTRIPSY	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0
90.00	09000	CLINIC	0.838384	797	668
90.01	09001	PAIN MANAGEMENT CLINIC	1.174008	0	0
91.00	09100	EMERGENCY	0.438645	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.926863	0	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0
200.00		Total (sum of lines 50 through 94 and 96 through 98)		548,714	294,983
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		548,714	294,983

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1343 Component CCN: 14-6150	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3 Date/Time Prepared: 10/29/2020 9:00 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
42.00	04200 SUBPROVIDER (SPECIFY)		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.341880	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.345258	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.210763	5,604	1,181	54.00
54.01	05401 RADIOLOGY-ULTRASOUND	0.169211	1,518	257	54.01
60.00	06000 LABORATORY	0.217310	56,210	12,215	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.432141	5,216	2,254	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.703844	31,957	22,493	65.00
66.00	06600 PHYSICAL THERAPY	0.638204	291,016	185,728	66.00
69.00	06900 ELECTROCARDIOLOGY	0.105097	755	79	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.695393	6,410	4,457	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.855941	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.586299	31,855	18,677	73.00
76.00	03950 CARDIAC REHAB	0.619523	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	0.838384	0	0	90.00
90.01	09001 PAIN MANAGEMENT CLINIC	1.174008	0	0	90.01
91.00	09100 EMERGENCY	0.438645	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.926863	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		430,541	247,341	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		430,541		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet D-3
			Component CCN: 14-Z343		Date/Time Prepared: 10/29/2020 9:00 am
			Title XIX	Swing Beds - SNF	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
42.00	04200	SUBPROVIDER (SPECIFY)		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	0	54.01
60.00	06000	LABORATORY	0.000000	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	88.02
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	PAIN MANAGEMENT CLINIC	0.000000	0	90.01
91.00	09100	EMERGENCY	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet E Part B Date/Time Prepared: 10/29/2020 9:00 am
		Title XVIII	Hospital	Cost
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,496,831	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)		8,496,831	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		8,581,799	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)		76,867	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,547,340	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)		4,957,592	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)		4,957,592	30.00
31.00	Primary payer payments		1,212	31.00
32.00	Subtotal (line 30 minus line 31)		4,956,380	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)		317,145	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		206,144	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		166,698	36.00
37.00	Subtotal (see instructions)		5,162,524	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)		5,162,524	40.00
40.01	Sequestration adjustment (see instructions)		103,250	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		4,780,842	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)		278,432	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: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part I
Date/Time Prepared:
10/29/2020 9:00 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,364,319		4,720,301	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	11/13/2019	78,833	11/13/2020	60,541	3.01
3.02		04/08/2020	8,068		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)		86,901		60,541	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,451,220		4,780,842	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		121,123		278,432	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,572,343		5,059,274	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: 14-1343

Period:

Worksheet E-1

Component CCN: 14-Z343

From 05/01/2019

Part I

To 04/30/2020

Date/Time Prepared:

10/29/2020 9:00 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,578,855		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	04/08/2020	25,378		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		25,378		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,604,233		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		107,703		0	6.02
7.00	Total Medicare program liability (see instructions)		1,496,530		0	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: 14-1343
 Component CCN: 14-6150

 Period:
 From 05/01/2019
 To 04/30/2020

 Worksheet E-1
 Part I
 Date/Time Prepared:
 10/29/2020 9:00 am

Title XVIII

 Skilled Nursing
 Facility

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		406,808		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		406,808		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		406,808		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet E-1
Part II
Date/Time Prepared:
10/29/2020 9:00 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1343

Period:

Worksheet E-2

Component CCN: 14-Z343

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,266,415	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)		297,933	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		853	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,564,348	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,564,348	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,564,348	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		39,550	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,524,798	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)		3,497	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		2,273	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,497	0	18.00
19.00	Total (see instructions)		1,527,071	0	19.00
19.01	Sequestration adjustment (see instructions)		30,541	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,604,233	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)		-107,703	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: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet E-3 Part V Date/Time Prepared: 10/29/2020 9:00 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,894,588 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,894,588 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,923,534 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,923,534 19.00
20.00	Deductibles (exclude professional component)			318,252 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,605,282 22.00
23.00	Coinsurance			1,364 23.00
24.00	Subtotal (line 22 minus line 23)			2,603,918 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			32,188 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			20,922 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			25,327 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,624,840 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			2,624,840 30.00
30.01	Sequestration adjustment (see instructions)			52,497 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM			0 30.03
31.00	Interim payments			2,451,220 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)			121,123 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1343 Component CCN: 14-6150	Period: From 05/01/2019 To 04/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 10/29/2020 9:00 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			503,831
2.00	Routine service other pass through costs			0
3.00	Ancillary service other pass through costs			0
4.00	Subtotal (sum of lines 1 through 3)			503,831
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0
7.00	Coinsurance			88,721
8.00	Allowable bad debts (see instructions)			0
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
10.00	Adjusted reimbursable bad debts (see instructions)			0
11.00	Utilization review			0
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			415,110
13.00	Inpatient primary payer payments			0
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
14.99	Demonstration payment adjustment amount before sequestration			0
15.00	Subtotal (see instructions)			415,110
15.01	Sequestration adjustment (see instructions)			8,302
15.02	Demonstration payment adjustment amount after sequestration			0
16.00	Interim payments			406,808
17.00	Tentative settlement (for contractor use only)			0
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)			0
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0

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

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet G

Date/Time Prepared:
10/29/2020 9:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	20,530,158	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,341,886	0	0	0	4.00
5.00	Other receivable	4,127,330	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,031,000	0	0	0	6.00
7.00	Inventory	1,140,727	0	0	0	7.00
8.00	Prepaid expenses	824,062	0	0	0	8.00
9.00	Other current assets	474,657	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	33,407,820	0	0	0	11.00
FIXED ASSETS						
12.00	Land	540,645	0	0	0	12.00
13.00	Land improvements	1,325,717	0	0	0	13.00
14.00	Accumulated depreciation	-727,516	0	0	0	14.00
15.00	Buildings	56,596,660	0	0	0	15.00
16.00	Accumulated depreciation	-29,132,599	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	20,205,965	0	0	0	23.00
24.00	Accumulated depreciation	-12,309,538	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	36,499,334	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	18,644,985	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	4,707,288	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	23,352,273	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	93,259,427	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,207,600	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,541,256	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	1,586,244	0	0	0	41.00
42.00	Accelerated payments	6,779,442	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,464,820	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,579,362	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	27,823,812	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	4,707,288	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	32,531,100	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	46,110,462	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	47,148,965	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)	47,148,965	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	93,259,427	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-1

Date/Time Prepared:
10/29/2020 9:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		48,412,320		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,263,355				2.00
3.00	Total (sum of line 1 and line 2)		47,148,965		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		47,148,965		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFER PERM RESTRICTED	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)		47,148,965		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFER PERM RESTRICTED		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: 14-1343

Period:
From 05/01/2019
To 04/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,205,827		4,205,827	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER (SPECIFY)	0		0	4.00
5.00	Swing bed - SNF	1,830,658		1,830,658	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	846,419		846,419	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)	6,882,904		6,882,904	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)	6,882,904		6,882,904	17.00
18.00	Ancillary services	9,782,076	54,302,628	64,084,704	18.00
19.00	Outpatient services	0	19,138,813	19,138,813	19.00
20.00	RURAL HEALTH CLINIC	0	5,918,971	5,918,971	20.00
20.01	RURAL HEALTH CLINIC II	0	483,892	483,892	20.01
20.02	RURAL HEALTH CLINIC III	0	1,194,363	1,194,363	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		852,097	852,097	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICE	0	16,867	16,867	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,664,980	81,907,631	98,572,611	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52,774,189		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	RECONCILING ITEM	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)		52,774,189		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1343

Period:
From 05/01/2019
To 04/30/2020

Worksheet G-3

Date/Time Prepared:
10/29/2020 9:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	98,572,611	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,564,473	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,008,138	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	52,774,189	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,766,051	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	3,165	6.00
7.00	Income from investments	400,670	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	207,185	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	14,841	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	252,112	22.00
23.00	Governmental appropriations	0	23.00
24.00	CONSULTING CLINIC	0	24.00
24.01	WELLNESS	32,771	24.01
24.02	GRANTS	3,500,000	24.02
24.03	MEANING FULL USE	0	24.03
24.04	FOUNDATION REIMBURSEMENT	0	24.04
24.05	DONATIONS	0	24.05
24.06	OTHER INCOME	76,149	24.06
24.07	TAX SUPPORT	1,015,803	24.07
25.00	Total other income (sum of lines 6-24)	5,502,696	25.00
26.00	Total (line 5 plus line 25)	-1,263,355	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,263,355	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN: 14-1343 HHA CCN: 14-7175	Period: From 05/01/2019 To 04/30/2020	Worksheet H Date/Time Prepared: 10/29/2020 9:00 am
					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	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	4.00
5.00	Administrative and General	120,154	9,012	49	14,763	15,791	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	250,775	18,808	12,006	0	281,589	6.00
7.00	Physical Therapy	52,214	3,916	7,055	0	63,185	7.00
8.00	Occupational Therapy	11,860	890	1,106	0	13,856	8.00
9.00	Speech Pathology	1,178	88	140	0	1,406	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	51,195	3,840	4,959	0	59,994	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	487,376	36,554	25,315	14,763	579,799	24.00
	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		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	159,769	0	159,769		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	281,589	0	281,589		6.00
7.00	Physical Therapy	0	63,185	0	63,185		7.00
8.00	Occupational Therapy	0	13,856	0	13,856		8.00
9.00	Speech Pathology	0	1,406	0	1,406		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	59,994	0	59,994		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	0	579,799	0	579,799		24.00

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: 14-1343 HHA CCN: 14-7175		Period: From 05/01/2019 To 04/30/2020		Worksheet H-1 Part I Date/Time Prepared: 10/29/2020 9:00 am	
						Home 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	159,769	0	0	0	0	159,769	5.00	
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	281,589	0	0	0	0	281,589	6.00	
7.00	Physical Therapy	63,185	0	0	0	0	63,185	7.00	
8.00	Occupational Therapy	13,856	0	0	0	0	13,856	8.00	
9.00	Speech Pathology	1,406	0	0	0	0	1,406	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	59,994	0	0	0	0	59,994	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	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)	579,799	0	0	0	0	579,799	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	159,769						5.00	
HHA REIMBURSABLE SERVICES									
6.00	Skilled Nursing Care	129,845	411,434					6.00	
7.00	Physical Therapy	13,944	77,129					7.00	
8.00	Occupational Therapy	3,110	16,966					8.00	
9.00	Speech Pathology	133	1,539					9.00	
10.00	Medical Social Services	0	0					10.00	
11.00	Home Health Aide	12,737	72,731					11.00	
12.00	Supplies (see instructions)	0	0					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)		579,799					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1343

Period:

Worksheet H-1

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part II
Date/Time Prepared:
10/29/2020 9:00 amHome 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	4.00	5A.00	5.00		
	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	-159,769	412,012	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	53,254	334,843	6.00	
7.00	Physical Therapy	0	0	0	0	-27,226	35,959	7.00	
8.00	Occupational Therapy	0	0	0	0	-5,835	8,021	8.00	
9.00	Speech Pathology	0	0	0	0	-1,062	344	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	0	0	0	0	-27,149	32,845	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	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	-167,787	412,012	24.00	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		159,769	25.00	
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.387778	26.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1343

Period:

Worksheet H-2

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
10/29/2020 9:00 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	9,909	1,718	24,906	616	0	1.00
2.00	Skilled Nursing Care	411,434	0	0	51,984	0	0	2.00
3.00	Physical Therapy	77,129	0	0	10,823	0	0	3.00
4.00	Occupational Therapy	16,966	0	0	2,458	0	0	4.00
5.00	Speech Pathology	1,539	0	0	244	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	72,731	0	0	10,612	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	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	579,799	9,909	1,718	101,027	616	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		PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.03	5.04	5.05	5A.05	5.06	6.00	
1.00	Administrative and General	1,440	0	38,199	76,788	6,845	0	1.00
2.00	Skilled Nursing Care	0	0	0	463,418	77,408	0	2.00
3.00	Physical Therapy	0	0	0	87,952	8,187	0	3.00
4.00	Occupational Therapy	0	0	0	19,424	1,832	0	4.00
5.00	Speech Pathology	0	0	0	1,783	73	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	83,343	7,477	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	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,440	0	38,199	732,708	101,822	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: 14-1343

Period:

Worksheet H-2

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
10/29/2020 9:00 amHome Health
Agency I

PPS

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	0	0	2,625	0	19,419	0	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	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	2,625	0	19,419	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		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	65,402	0	0	0	1,017	0	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	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	65,402	0	0	0	1,017	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

(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: 14-1343

Period:

Worksheet H-2

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
10/29/2020 9:00 amHome Health
Agency I

PPS

Cost Center Description		INTERNS & RESIDENTS			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		NURSING SCHOOL	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		20.00	21.00	22.00	23.00	24.00	25.00	
1.00	Administrative and General	0	0	0	0	172,096	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	540,826	0	2.00
3.00	Physical Therapy	0	0	0	0	96,139	0	3.00
4.00	Occupational Therapy	0	0	0	0	21,256	0	4.00
5.00	Speech Pathology	0	0	0	0	1,856	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	90,820	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	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	922,993	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		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	172,096						1.00
2.00	Skilled Nursing Care	540,826	123,950	664,776				2.00
3.00	Physical Therapy	96,139	22,034	118,173				3.00
4.00	Occupational Therapy	21,256	4,872	26,128				4.00
5.00	Speech Pathology	1,856	425	2,281				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	90,820	20,815	111,635				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	922,993	172,096	922,993				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.		0.229187					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: 14-1343

Period:

Worksheet H-2

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part II
Date/Time Prepared:
10/29/2020 9:00 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			NONPATIENT TELEPHONES (#OF PHONES)	DATA PROCESSING (MACHINE TIME)	PURCHASING RECEIVING AND STORES (COST REQ'S)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE NEW)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SAL)				
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	450	1,833	120,154	9	0	22,349	1.00
2.00	Skilled Nursing Care	0	0	250,775	0	0	0	2.00
3.00	Physical Therapy	0	0	52,214	0	0	0	3.00
4.00	Occupational Therapy	0	0	11,860	0	0	0	4.00
5.00	Speech Pathology	0	0	1,178	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	51,195	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	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	450	1,833	487,376	9	0	22,349	20.00
21.00	Total cost to be allocated	9,909	1,718	101,027	616	0	1,440	21.00
22.00	Unit cost multiplier	22.020000	0.937261	0.207288	68.444444	0.000000	0.064432	22.00
Cost Center Description		ADMITTING (INPATIENT REVENUE)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		5.04	5.05	5A.06	5.06	6.00	7.00	
1.00	Administrative and General	0	852,097	-29,139	47,649	0	0	1.00
2.00	Skilled Nursing Care	0	0	75,437	538,855	0	0	2.00
3.00	Physical Therapy	0	0	-30,962	56,990	0	0	3.00
4.00	Occupational Therapy	0	0	-6,670	12,754	0	0	4.00
5.00	Speech Pathology	0	0	-1,273	510	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	-31,296	52,047	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	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	852,097		708,805	0	0	20.00
21.00	Total cost to be allocated	0	38,199		101,822	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.044829		0.143653	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1343

Period:

Worksheet H-2

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part II
Date/Time Prepared:
10/29/2020 9:00 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS)		HOUSEKEEPING (SQUARE FEET)		DIETARY (MEALS)		CAFETERIA (FTE'S)		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)		NURSING ADMINISTRATION (NURSING HOURS)		
		8.00		9.00		10.00		11.00		12.00		13.00		
1.00	Administrative and General	0		450		0		8		0		16,168		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		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		450		0		8		0		16,168		20.00
21.00	Total cost to be allocated	0		2,625		0		19,419		0		65,402		21.00
22.00	Unit cost multiplier	0.000000		5.833333		0.000000		2,427.375000		0.000000		4.045151		22.00
Cost Center Description		CENTRAL SERVICES & SUPPLY (CSS CSTED REQ')		PHARMACY (RX CSTD REQ'S)		MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		SOCIAL SERVICE (TIME)		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		NURSING SCHOOL (ASSIGNED TIME)		
		14.00		15.00		16.00		17.00		19.00		20.00		
1.00	Administrative and General	0		0		0		1		0		0		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		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		0		0		1		0		0		20.00
21.00	Total cost to be allocated	0		0		0		1,017		0		0		21.00
22.00	Unit cost multiplier	0.000000		0.000000		0.000000		1,017.000000		0.000000		0.000000		22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1343

Period:

Worksheet H-2

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part II
Date/Time Prepared:
10/29/2020 9:00 amHome Health
Agency I

PPS

Cost Center Description		INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)		
		SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
		21.00	22.00			
1.00	Administrative and General	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1343

Period:

Worksheet H-3

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
10/29/2020 9:00 am

Title XVIII

Home Health
Agency I

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	664,776		664,776	1,750	379.87	1.00
2.00	Physical Therapy	3.00	118,173	0	118,173	986	119.85	2.00
3.00	Occupational Therapy	4.00	26,128	0	26,128	189	138.24	3.00
4.00	Speech Pathology	5.00	2,281	0	2,281	41	55.63	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	111,635		111,635	378	295.33	6.00
7.00	Total (sum of lines 1-6)		922,993	0	922,993	3,344		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	788			8.00
9.00	Physical Therapy		99914	0	421			9.00
10.00	Occupational Therapy		99914	0	89			10.00
11.00	Speech Pathology		99914	0	22			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	205			13.00
14.00	Total (sum of lines 8-13)			0	1,525			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	0	13,736	13,736	19,753	0.695388	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
				Program Visits		Cost of Services		
				Part B				
				Not 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	788		0	299,338		1.00
2.00	Physical Therapy	0	421		0	50,457		2.00
3.00	Occupational Therapy	0	89		0	12,303		3.00
4.00	Speech Pathology	0	22		0	1,224		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	205		0	60,543		6.00
7.00	Total (sum of lines 1-6)	0	1,525		0	423,865		7.00
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1343

Period:

Worksheet H-3

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part I
Date/Time Prepared:
10/29/2020 9:00 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		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
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	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	299,338						1.00
2.00	Physical Therapy	50,457						2.00
3.00	Occupational Therapy	12,303						3.00
4.00	Speech Pathology	1,224						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	60,543						6.00
7.00	Total (sum of lines 1-6)	423,865						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1343

Period:

Worksheet H-3

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Part II
Date/Time Prepared:
10/29/2020 9:00 am

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	0.638204	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	0.695393	19,753	13,736	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.586299	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1343 HHA CCN: 14-7175	Period: From 05/01/2019 To 04/30/2020	Worksheet H-4 Part I-II Date/Time Prepared: 10/29/2020 9:00 am	
		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	0	1.00
2.00	Total charges	0	0	0	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	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	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	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	219,154	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	3,250	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	2,044	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	617	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	225,065	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	225,065	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	225,065	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	225,065	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	225,065	31.00
31.01	Sequestration adjustment (see instructions)		0	8,399	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	216,666	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 BENEFICIARIES

Provider CCN: 14-1343

Period:

Worksheet H-5

HHA CCN: 14-7175

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 amHome 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		216,666	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		216,666	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		216,666	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 RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3429

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,207,389	0	2,207,389	-23,727	2,183,662 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	248,839	0	248,839	0	248,839 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	0	0	0	0	0 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	1,024,496	192,379	1,216,875	0	1,216,875 9.00
10.00	Subtotal (sum of lines 1 through 9)	3,480,724	192,379	3,673,103	-23,727	3,649,376 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	140,742	140,742	0	140,742 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	19,052	19,052	0	19,052 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	159,794	159,794	0	159,794 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,480,724	352,173	3,832,897	-23,727	3,809,170 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	33,383	0	33,383	0	33,383 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	33,383	0	33,383	0	33,383 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	114,685	114,685	0	114,685 29.00
30.00	Administrative Costs	0	496,230	496,230	0	496,230 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	610,915	610,915	0	610,915 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,514,107	963,088	4,477,195	-23,727	4,453,468 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3429

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-284,700	1,898,962	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	-54,921	193,918	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	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	1,216,875	9.00
10.00	Subtotal (sum of lines 1 through 9)	-339,621	3,309,755	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	140,742	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	19,052	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	159,794	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-339,621	3,469,549	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	33,383	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	33,383	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	114,685	29.00
30.00	Administrative Costs	-6,465	489,765	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-6,465	604,450	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-346,086	4,107,382	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3486

From 05/01/2019

Date/Time Prepared:

To 04/30/2020

10/29/2020 9:00 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	2.00
3.00	Nurse Practitioner	125,753	0	125,753	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	141,386	18,890	160,276	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	267,139	18,890	286,029	0	10.00
11.00	Physician Services Under Agreement	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	14.00
15.00	Medical Supplies	0	16,966	16,966	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	5,220	5,220	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,186	22,186	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	267,139	41,076	308,215	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
25.01	Telehealth	641	0	641	0	25.01
25.02	Chronic Care Management	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	641	0	641	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	18,960	18,960	0	29.00
30.00	Administrative Costs	0	40,573	40,573	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	59,533	59,533	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	267,780	100,609	368,389	0	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3486

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-42,000	-42,000		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	125,753		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	-2,788	157,488		9.00
10.00	Subtotal (sum of lines 1 through 9)	-44,788	241,241		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	16,966		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	5,220		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22,186		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-44,788	263,427		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	641		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	641		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	18,960		29.00
30.00	Administrative Costs	0	40,573		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	59,533		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-44,788	323,601		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3488

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 am

		RHC III		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	237,624	0	237,624	10,481	248,105
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	233,471	0	233,471	0	233,471
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
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	249,713	52,682	302,395	0	302,395
10.00	Subtotal (sum of lines 1 through 9)	720,808	52,682	773,490	10,481	783,971
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	23,182	23,182	0	23,182
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	8,131	8,131	0	8,131
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	31,313	31,313	0	31,313
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	720,808	83,995	804,803	10,481	815,284
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	13,991	0	13,991	0	13,991
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	13,991	0	13,991	0	13,991
FACILITY OVERHEAD						
29.00	Facility Costs	0	41,142	41,142	0	41,142
30.00	Administrative Costs	0	27,526	27,526	0	27,526
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	68,668	68,668	0	68,668
32.00	Total facility costs (sum of lines 22, 28 and 31)	734,799	152,663	887,462	10,481	897,943

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1343

Period:

Worksheet M-1

Component CCN: 14-3488

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC III	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-10,347	237,758		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	233,471		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	302,395		9.00
10.00	Subtotal (sum of lines 1 through 9)	-10,347	773,624		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	23,182		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	8,131		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	31,313		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-10,347	804,937		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	13,991		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	13,991		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	41,142		29.00
30.00	Administrative Costs	0	27,526		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	68,668		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-10,347	887,596		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343

Period:

Worksheet M-2

Component CCN: 14-3429

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	5.65	19,689	4,200	23,730		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.58	6,011	2,100	3,318		3.00
4.00	Subtotal (sum of lines 1 through 3)	7.23	25,700		27,048	27,048	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	7.23	25,700			27,048	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					3,469,549	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					33,383	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,502,932	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990470	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					604,450	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,153,743	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,758,193	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,758,193	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,731,907	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					6,201,456	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343

Period:

Worksheet M-2

Component CCN: 14-3486

From 05/01/2019
To 04/30/2020Date/Time Prepared:
10/29/2020 9:00 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.00	0	4,200	0
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.79	2,687	2,100	1,659
4.00	Subtotal (sum of lines 1 through 3)	0.79	2,687		1,659
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.79	2,687		2,687
9.00	Physician Services Under Agreements		0		0
					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)				263,427
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				641
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				264,068
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.997573
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				59,533
15.00	Parent provider overhead allocated to facility (see instructions)				366,743
16.00	Total overhead (sum of lines 14 and 15)				426,276
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				426,276
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				425,241
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				688,668

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1343

Period:

Worksheet M-2

Component CCN: 14-3488

From 05/01/2019

Date/Time Prepared:

To 04/30/2020

10/29/2020 9:00 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.87	2,611	4,200	3,654		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.78	3,209	2,100	1,638		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.65	5,820		5,292	5,820	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.65	5,820			5,820	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)					804,937	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,991	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					818,928	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.982915	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					68,668	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					432,193	15.00
16.00	Total overhead (sum of lines 14 and 15)					500,861	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					500,861	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					492,304	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,297,241	20.00

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet M-3		
		Component CCN: 14-3429		Date/Time Prepared: 10/29/2020 9:00 am		
		Title XVIII	RHC I	Cost		
			1.00			
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			6,201,456	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			125,399	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			6,076,057	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			27,048	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)			27,048	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			224.64	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)			224.64	224.64	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	6,443	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	1,447,356	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	1,447,356	16.00
16.01	Total program charges (see instructions)(from contractor's records)				1,126,118	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				104,355	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				134,124	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.)				951,358	16.04
16.05	Total program cost (see instructions)			0	1,085,482	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				124,034	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				179,338	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				1,085,482	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				75,181	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				1,160,663	22.00
23.00	Allowable bad debts (see instructions)				60,429	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				39,279	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)				1,199,942	26.00
26.01	Sequestration adjustment (see instructions)				23,999	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				966,916	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)				209,027	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet M-3		
		Component CCN: 14-3486		Date/Time Prepared: 10/29/2020 9:00 am		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			688,668	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			26,684	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			661,984	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,687	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)			2,687	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			246.37	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)			246.37	246.37	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	504	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	124,170	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	124,170	16.00
16.01	Total program charges (see instructions)(from contractor's records)				85,681	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				19,229	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				27,867	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.)				67,810	16.04
16.05	Total program cost (see instructions)			0	95,677	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				11,540	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				12,399	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				95,677	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				15,996	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				111,673	22.00
23.00	Allowable bad debts (see instructions)				7,731	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				5,025	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)				116,698	26.00
26.01	Sequestration adjustment (see instructions)				2,334	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				40,813	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)				73,551	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

Health Financial Systems		CRAWFORD MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1343	Period: From 05/01/2019 To 04/30/2020	Worksheet M-3	
		Component CCN: 14-3488		Date/Time Prepared: 10/29/2020 9:00 am	
		Title XVIII	RHC III	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)			1,297,241	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			11,339	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,285,902	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,820	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)			5,820	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			220.95	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)			0.00	8.00
9.00	Rate for Program covered visits (see instructions)			220.95	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)			0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			171,899	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	13.00
14.00	Limit adjustment for mental health services (see instructions)			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	16.00
16.01	Total program charges (see instructions)(from contractor's records)			137,397	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			8,636	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			10,805	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.)			118,344	16.04
16.05	Total program cost (see instructions)			0	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			13,164	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			23,119	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			129,149	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			6,557	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			135,706	22.00
23.00	Allowable bad debts (see instructions)			4,936	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			3,208	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)			138,914	26.00
26.01	Sequestration adjustment (see instructions)			2,778	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			83,507	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)			52,629	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: 14-1343 Component CCN: 14-3429	Period: From 05/01/2019 To 04/30/2020	Worksheet M-4 Date/Time Prepared: 10/29/2020 9:00 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		3,309,755	3,309,755	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000393	0.004954	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,301	16,397	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		36,063	16,396	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		37,364	32,793	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		3,469,549	3,469,549	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,731,907	2,731,907	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010769	0.009452	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		29,420	25,822	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		66,784	58,615	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		204	1,041	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		327.37	56.31	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		155	434	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		50,742	24,439	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)			125,399	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)			75,181	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1343 Component CCN: 14-3486	Period: From 05/01/2019 To 04/30/2020	Worksheet M-4 Date/Time Prepared: 10/29/2020 9:00 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		241,241	241,241	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001306	0.005222	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		315	1,260	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		6,364	2,268	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		6,679	3,528	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		263,427	263,427	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		425,241	425,241	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.025354	0.013393	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		10,782	5,695	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		17,461	9,223	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		36	144	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		485.03	64.05	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		24	68	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		11,641	4,355	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)			26,684	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)			15,996	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1343 Component CCN: 14-3488	Period: From 05/01/2019 To 04/30/2020	Worksheet M-4 Date/Time Prepared: 10/29/2020 9:00 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		773,624	773,624	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000200	0.001707	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		155	1,321	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,182	2,378	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,337	3,699	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		804,937	804,937	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		492,304	492,304	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.004146	0.004595	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		2,041	2,262	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		5,378	5,961	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		18	151	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		298.78	39.48	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		16	45	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		4,780	1,777	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)			11,339	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)			6,557	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1343 Component CCN: 14-3429	Period: From 05/01/2019 To 04/30/2020	Worksheet M-5 Date/Time Prepared: 10/29/2020 9:00 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		966,916	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		966,916	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		209,027	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,175,943	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1343 Component CCN: 14-3486	Period: From 05/01/2019 To 04/30/2020	Worksheet M-5 Date/Time Prepared: 10/29/2020 9:00 am	
			RHC II	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		40,813	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		40,813		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		73,551		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		114,364		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1343 Component CCN: 14-3488	Period: From 05/01/2019 To 04/30/2020	Worksheet M-5 Date/Time Prepared: 10/29/2020 9:00 am	
			RHC III	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		83,507	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		83,507		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		52,629		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		136,136		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00