

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: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 1/27/2021 4:30 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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.		Date: 1/27/2021 Time: 4:30 pm
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 LAWRENCE COUNTY MEMORIAL HOSPITAL (14-1344) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DON ROBBINS
 Officer or Administrator of Provider(s)

CEO
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	815,347	1,251,703	0	4,523	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	429,630	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		96,052		0	10.00
200.00	Total	0	1,244,977	1,347,755	0	4,523	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: 14-1344		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/27/2021 4:30 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 2100 STATE STREET			PO Box:				1.00		
2.00	City: LAWRENCEVILLE			State: IL		Zip Code: 62439		County: LAWRENCE 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		LAWRENCE COUNTY MEMORIAL HOSPITAL	141344	99914	1	04/01/2005	N	O	O
4.00	Subprovider - IPF									3.00
5.00	Subprovider - IRF									4.00
6.00	Subprovider - (Other)									5.00
7.00	Swing Beds - SNF		LAWRENCE COUNTY MEMORIAL HOSPITAL	14Z344	99914		04/01/2005	N	O	N
8.00	Swing Beds - NF									6.00
9.00	Hospital-Based SNF									7.00
10.00	Hospital-Based NF									8.00
11.00	Hospital-Based OLTC									9.00
12.00	Hospital-Based HHA									10.00
13.00	Separately Certified ASC									11.00
14.00	Hospital-Based Hospice									12.00
15.00	Hospital-Based Health Clinic - RHC		LCMH PRIMARY CARE CLINIC	143499	99914		03/26/2009	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									13.00
17.00	Hospital-Based (CMHC) I									14.00
18.00	Renal Dialysis									15.00
19.00	Other									16.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2019		06/30/2020		
21.00	Type of Control (see instructions)					2				
						1.00		2.00		
						2.00		3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N			22.00	
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: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

	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 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 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: 14-1344		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/27/2021 4:30 pm			
			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)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
			1.00	2.00	3.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/27/2021 4:30 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	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.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	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: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/27/2021 4:30 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	142,381	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
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: 14-1344		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/27/2021 4:30 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00	
158.00	SUBPROVIDER							158.00	
159.00	SNF	N	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	N	161.00	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00	
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 1/27/2021 4:30 pm
			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	01/22/2021	Y 01/22/2021
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 1/27/2021 4:30 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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.	618-529-1040	MARKD@KEBCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

		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: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	20,520.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,150	20,520.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,150	20,520.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	594	29	855			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	312	0	318			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	906	29	1,173			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)	906	29	1,173	0.00	115.75	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,314	7,314	22,957	0.00	22.09	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	137.84	27.00
28.00	Observation Bed Days		74	279			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			10			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	174	29	222	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	174	29	222	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
1/27/2021 4:30 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	0	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

Health Financial Systems		LAWRENCE COUNTY MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1344 Component CCN: 14-3499		Period: From 07/01/2019 To 06/30/2020
			Worksheet S-8		Date/Time Prepared: 1/27/2021 4:30 pm
			RHC I		Cost
			1.00		
Clinic Address and Identification					
1.00	Street		2111 LEXINGTON		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		LAWRENCEVILLE IL 62439		2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
			1.00		2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
		1.00		2.00	5.00
Facility hours of operations (1)					
11.00	CLINIC		08:00	17:00	08:00
			1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		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
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
			County		
			4.00		
2.00	City, State, ZIP Code, County		LAWRENCE		2.00
		Tuesday	Wednesday		Thursday
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00			
Facility hours of operations (1)					
11.00	CLINIC		17:00	08:00	17:00
			08:00		17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1344 Component CCN: 14-3499		Period: From 07/01/2019 To 06/30/2020	Worksheet S-8 Date/Time Prepared: 1/27/2021 4:30 pm
					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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 1/27/2021 4:30 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.596330 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	3,851,965		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	8,028,661		6.00
7.00	Medicaid cost (line 1 times line 6)	4,787,731		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)	935,766		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)	935,766		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)	1,158,995	414,172	1,573,167 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	691,143	414,172	1,105,315 21.00
22.00	Payments received from patients for amounts previously written off as charity care	47,127	18,281	65,408 22.00
23.00	Cost of charity care (line 21 minus line 22)	644,016	395,891	1,039,907 23.00
				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)	842,624		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	92,807		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	142,780		27.01
28.00	Non-Medicare bad debt expense (see instructions)	699,844		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	467,311		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,507,218		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,442,984		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1344

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

Worksheet A

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		488,399	488,399	0	488,399	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		312,228	312,228	0	312,228	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	27,679	2,332,588	2,360,267	50,394	2,410,661	4.00
5.01	00580	ADMINISTRATIVE & GENERAL	352,851	314,874	667,725	0	667,725	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	79,484	28,479	107,963	0	107,963	5.02
5.03	01160	COMMUNICATIONS	0	46,272	46,272	0	46,272	5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL	495,190	2,563,341	3,058,531	-50,394	3,008,137	5.04
6.00	00600	MAINTENANCE & REPAIRS	189,614	194,641	384,255	0	384,255	6.00
7.00	00700	OPERATION OF PLANT	0	152,141	152,141	0	152,141	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,954	97,954	0	97,954	8.00
9.00	00900	HOUSEKEEPING	263,541	36,859	300,400	0	300,400	9.00
10.00	01000	DIETARY	202,305	201,872	404,177	-363,316	40,861	10.00
11.00	01100	CAFETERIA	0	0	0	363,316	363,316	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	195,346	12,281	207,627	0	207,627	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,082	16,082	0	16,082	14.00
15.00	01500	PHARMACY	229,434	94,571	324,005	0	324,005	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	242,514	66,000	308,514	0	308,514	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	57,390	57,390	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	12,569	12,569	207,645	220,214	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,182,426	51,180	1,233,606	-57,390	1,176,216	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	256,538	189,479	446,017	-12,454	433,563	50.00
53.00	05300	ANESTHESIOLOGY	207,645	25,238	232,883	-207,645	25,238	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	372,091	353,085	725,176	0	725,176	54.00
57.00	05700	CT SCAN	0	101,405	101,405	0	101,405	57.00
58.00	05800	MRI	0	133,365	133,365	0	133,365	58.00
60.00	06000	LABORATORY	488,221	273,132	761,353	0	761,353	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	23,917	23,917	0	23,917	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	194,686	29,485	224,171	0	224,171	65.00
66.00	06600	PHYSICAL THERAPY	183,999	7,654	191,653	0	191,653	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	88,228	542	88,770	0	88,770	67.00
68.00	06800	SPEECH PATHOLOGY	27,355	0	27,355	0	27,355	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,115	1,115	0	1,115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,454	12,454	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	407,685	407,685	0	407,685	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	3,166	3,166	0	3,166	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,691,440	214,137	1,905,577	12,962	1,918,539	88.00
90.00	09000	CLINIC	346,170	278,206	624,376	0	624,376	90.00
91.00	09100	EMERGENCY	507,502	1,416,434	1,923,936	0	1,923,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,824,259	10,480,376	18,304,635	12,962	18,317,597	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,837	20,837	-12,962	7,875	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,824,259	10,501,213	18,325,472	0	18,325,472	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1344

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

Worksheet A

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	488,399	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-28,706	283,522	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-567	2,410,094	4.00
5.01	00580	ADMINISTRATIVE & GENERAL	-9,100	658,625	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-25,083	82,880	5.02
5.03	01160	COMMUNICATIONS	0	46,272	5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL	1,132,808	4,140,945	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	384,255	6.00
7.00	00700	OPERATION OF PLANT	0	152,141	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,954	8.00
9.00	00900	HOUSEKEEPING	0	300,400	9.00
10.00	01000	DIETARY	0	40,861	10.00
11.00	01100	CAFETERIA	-110,454	252,862	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	207,627	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,082	14.00
15.00	01500	PHARMACY	0	324,005	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,428	304,086	16.00
17.00	01700	SOCIAL SERVICE	0	57,390	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	220,214	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	02301	PARAMED ED PRGM- (SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,176,216	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	433,563	50.00
53.00	05300	ANESTHESIOLOGY	0	25,238	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	725,176	54.00
57.00	05700	CT SCAN	0	101,405	57.00
58.00	05800	MRI	0	133,365	58.00
60.00	06000	LABORATORY	-14,579	746,774	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	23,917	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-40	224,131	65.00
66.00	06600	PHYSICAL THERAPY	0	191,653	66.00
66.01	06601	CARDIAC REHAB	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	88,770	67.00
68.00	06800	SPEECH PATHOLOGY	0	27,355	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,454	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-224,769	182,916	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	-3,166	0	76.01
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	-33,252	1,885,287	88.00
90.00	09000	CLINIC	-267,438	356,938	90.00
91.00	09100	EMERGENCY	-133,245	1,790,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	277,981	18,595,578	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,875	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	277,981	18,603,453	200.00

RECLASSIFICATIONS

Provider CCN: 14-1344

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

Worksheet A-6

Date/Time Prepared:
1/27/2021 4:30 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - CAFETERIA RECLASS					1.00
	CAFETERIA	11.00	181,853	181,463		
	TOTALS		181,853	181,463		
1.00	B - RHC UTILITY RECLASS					1.00
	RURAL HEALTH CLINIC	88.00	0	12,962		
	TOTALS		0	12,962		
1.00	D - SALARIES RECLASS					1.00
	SOCIAL SERVICE	17.00	57,390	0		
	TOTALS		57,390	0		
1.00	E - SALARIES RECLASS					1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	50,394	0		
	TOTALS		50,394	0		
1.00	F - CRNA RECLASS					1.00
	NONPHYSICIAN ANESTHETISTS	19.00	207,645	0		
	TOTALS		207,645	0		
1.00	G - IMPLANT DEVICE COST RECLASS					1.00
	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,454		
	TOTALS		0	12,454		
500.00	Grand Total: Increases			497,282	206,879	500.00

RECLASSIFICATIONS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
1/27/2021 4:30 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
1.00	A - CAFETERIA RECLASS					1.00
	DIETARY	10.00	181,853	181,463	0	
	TOTALS		181,853	181,463		
1.00	B - RHC UTILITY RECLASS					1.00
	PHYSICIANS' PRIVATE OFFICES	192.00	0	12,962	0	
	TOTALS		0	12,962		
1.00	D - SALARIES RECLASS					1.00
	ADULTS & PEDIATRICS	30.00	57,390	0	0	
	TOTALS		57,390	0		
1.00	E - SALARIES RECLASS					1.00
	OTHER ADMINISTRATIVE AND GENERAL	5.04	50,394	0	0	
	TOTALS		50,394	0		
1.00	F - CRNA RECLASS					1.00
	ANESTHESIOLOGY	53.00	207,645	0	0	
	TOTALS		207,645	0		
1.00	G - IMPLANT DEVICE COST RECLASS					1.00
	OPERATING ROOM	50.00	0	12,454	0	
	TOTALS		0	12,454		
500.00	Grand Total: Decreases		497,282	206,879		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	20,150	0	0	0	0	1.00
2.00	Land Improvements	555,229	41,664	0	41,664	25,190	2.00
3.00	Buildings and Fixtures	9,222,100	82,252	0	82,252	65,016	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	512,010	0	0	0	0	5.00
6.00	Movable Equipment	3,018,675	448,087	0	448,087	21,000	6.00
7.00	HIT designated Assets	1,261,695	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,589,859	572,003	0	572,003	111,206	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,589,859	572,003	0	572,003	111,206	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	20,150	0				1.00
2.00	Land Improvements	571,703	0				2.00
3.00	Buildings and Fixtures	9,239,336	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	512,010	0				5.00
6.00	Movable Equipment	3,445,762	0				6.00
7.00	HIT designated Assets	1,261,695	0				7.00
8.00	Subtotal (sum of lines 1-7)	15,050,656	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	15,050,656	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	424,242	0	0	59,306	4,851	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	305,415	0	6,813	0	0	2.00
3.00	Total (sum of lines 1-2)	729,657	0	6,813	59,306	4,851	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	488,399				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	312,228				2.00
3.00	Total (sum of lines 1-2)	0	800,627				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,392,858	0	10,392,858	0.690525	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,657,798	0	4,657,798	0.309475	0	2.00
3.00	Total (sum of lines 1-2)	15,050,656	0	15,050,656	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	424,242	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	283,642	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	707,884	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	59,306	4,851	0	488,399	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-120	0	0	0	283,522	2.00
3.00	Total (sum of lines 1-2)	-120	59,306	4,851	0	771,921	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1344

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

Worksheet A-8

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-6,813	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-25,052	PURCHASING RECEIVING AND STORES	5.02	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	-422,152			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	2,422,759			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-110,454	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	B	-4,428	MEDICAL RECORDS & LIBRARY	16.00	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	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	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-21,773	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	PHYSICIAN MALPRACTICE COSTS	A	-6,228	EMERGENCY	91.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1344

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

Worksheet A-8

Date/Time Prepared:
1/27/2021 4:30 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 PHYSICIAN MALPRACTICE COSTS	A	-22,804	CLINIC	90.00	0	33.01
34.00 SALE OF INSTITUTIONAL MATERIALS	B	-31	PURCHASING RECEIVING AND STORES	5.02	0	34.00
34.01 340B COSTS	A	-224,769	DRUGS CHARGED TO PATIENTS	73.00	0	34.01
35.00 DONATIONS EXPENSE	A	-3,331	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	35.00
36.00 MISC REVENUE - ADMIN	A	-2,361	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	36.00
37.00 PHYSICIAN RECURITMENT	A	-36,883	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	37.00
38.00 TELEPHONE OFFSET	A	-120	CAP REL COSTS-MVBLE EQUIP	2.00	11	38.00
39.00 TELEPHONE OFFSET	A	-2,087	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	39.00
40.00 TELEPHONE OFFSET	A	-567	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00 LOBBYING EXPENSE	A	-6,676	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	41.00
42.00 PART B PHYSICIAN BILING COSTS	A	-9,100	ADMINISTRATIVE & GENERAL	5.01	0	42.00
43.00 ADVERTISING - ADMIN	A	-60,013	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	43.00
44.00 OCCUPATIONAL MED	A	-536	OCCUPATIONAL MEDICINE	76.01	0	44.00
44.01 ACCRUE DEACONESS MGMT FEE	A	-677,780	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	44.01
44.02 IL PROVIDER ASSESSMENT TAX	A	-500,820	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	44.02
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		277,981				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: 14-1344

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

Worksheet A-8-1

Date/Time Prepared:
1/27/2021 4:30 pm

	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	5.00	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE COST ALLOCATION	2,422,759	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,422,759	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.

	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	DEACONESS	0.04	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: 14-1344

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

Worksheet A-8-1

Date/Time Prepared:
1/27/2021 4:30 pm

	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	2,422,759	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	2,422,759			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	HOSPITAL		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: 14-1344

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

Worksheet A-8-2

Date/Time Prepared:
1/27/2021 4:30 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,326,220	127,017	1,199,203	0	0	1.00
2.00	90.00	CLINIC	244,634	244,634	0	0	0	2.00
3.00	60.00	LABORATORY	14,579	14,579	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	40	40	0	0	0	4.00
5.00	66.01	CARDIAC REHAB	0	0	0	0	0	5.00
6.00	76.01	OCCUPATIONAL MEDICINE	2,630	2,630	0	0	0	6.00
7.00	88.00	RURAL HEALTH CLINIC	407,885	33,252	374,633	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,995,988	422,152	1,573,836			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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	66.01	CARDIAC REHAB	0	0	0	0	0	5.00
6.00	76.01	OCCUPATIONAL MEDICINE	0	0	0	0	0	6.00
7.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	127,017		1.00
2.00	90.00	CLINIC	0	0	0	244,634		2.00
3.00	60.00	LABORATORY	0	0	0	14,579		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	40		4.00
5.00	66.01	CARDIAC REHAB	0	0	0	0		5.00
6.00	76.01	OCCUPATIONAL MEDICINE	0	0	0	2,630		6.00
7.00	88.00	RURAL HEALTH CLINIC	0	0	0	33,252		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	422,152		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			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	488,399	488,399			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	283,522		283,522		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,410,094	0	0	2,410,094	4.00
5.01	00580	ADMINISTRATIVE & GENERAL	658,625	13,055	0	109,784	781,464 5.01
5.02	00560	PURCHASING RECEIVING AND STORES	82,880	4,288	0	24,730	0 5.02
5.03	01160	COMMUNICATIONS	46,272	0	0	0	0 5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL	4,140,945	35,100	35,427	138,391	0 5.04
6.00	00600	MAINTENANCE & REPAIRS	384,255	0	0	58,995	0 6.00
7.00	00700	OPERATION OF PLANT	152,141	97,507	0	0	0 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	97,954	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	300,400	5,602	1,179	81,996	0 9.00
10.00	01000	DIETARY	40,861	6,330	85	6,363	0 10.00
11.00	01100	CAFETERIA	252,862	14,703	414	56,580	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	207,627	1,950	0	60,779	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,082	0	0	0	0 14.00
15.00	01500	PHARMACY	324,005	2,912	0	71,384	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	304,086	9,687	895	75,454	0 16.00
17.00	01700	SOCIAL SERVICE	57,390	308	0	17,856	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	220,214	0	0	64,605	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,176,216	78,005	16,242	350,036	27,048 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	433,563	59,638	83,711	79,817	52,969 50.00
53.00	05300	ANESTHESIOLOGY	25,238	346	17,126	0	6,424 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	725,176	8,206	36,089	115,770	90,785 54.00
57.00	05700	CT SCAN	101,405	5,214	45,576	0	105,055 57.00
58.00	05800	MRI	133,365	3,264	0	0	27,817 58.00
60.00	06000	LABORATORY	746,774	7,139	22,184	151,902	163,613 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,917	1,172	0	0	3,951 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	224,131	6,768	3,514	60,573	18,408 65.00
66.00	06600	PHYSICAL THERAPY	191,653	9,699	2,606	57,248	28,927 66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	88,770	0	0	27,451	8,763 67.00
68.00	06800	SPEECH PATHOLOGY	27,355	0	0	8,511	983 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,115	3,116	0	0	8,837 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,454	0	0	0	1,499 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	182,916	0	2,785	0	33,766 73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,885,287	68,868	6,868	526,263	93,137 88.00
90.00	09000	CLINIC	356,938	16,529	1,778	107,705	15,800 90.00
91.00	09100	EMERGENCY	1,790,691	14,697	4,962	157,901	93,682 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
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,595,578	474,103	281,441	2,410,094	781,464 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,875	14,296	2,081	0	0 192.00
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)	18,603,453	488,399	283,522	2,410,094	781,464 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			PURCHASING RECEIVING AND STORES	COMMUNICATIONS	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
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	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	111,898					5.02
5.03	01160	COMMUNICATIONS	0	46,272				5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL	8,312	5,141	4,363,316	4,363,316		5.04
6.00	00600	MAINTENANCE & REPAIRS	2,897	0	446,147	136,704	582,851	6.00
7.00	00700	OPERATION OF PLANT	33	1,082	250,763	76,836	130,364	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	97,954	30,014	0	8.00
9.00	00900	HOUSEKEEPING	3,154	271	392,602	120,297	7,490	9.00
10.00	01000	DIETARY	14,931	1,353	69,923	21,425	8,463	10.00
11.00	01100	CAFETERIA	0	0	324,559	99,448	19,657	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	172	812	271,340	83,141	2,607	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	16,082	4,928	0	14.00
15.00	01500	PHARMACY	19,962	541	418,804	128,326	3,893	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212	3,788	394,122	120,763	12,951	16.00
17.00	01700	SOCIAL SERVICE	60	1,082	76,696	23,500	412	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	284,819	87,271	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,393	7,847	1,657,787	507,963	104,289	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,041	4,871	722,610	221,415	79,733	50.00
53.00	05300	ANESTHESIOLOGY	1,378	271	50,783	15,560	462	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,089	2,165	982,280	300,980	10,971	54.00
57.00	05700	CT SCAN	1,032	271	258,553	79,223	6,970	57.00
58.00	05800	MRI	87	271	164,804	50,498	4,364	58.00
60.00	06000	LABORATORY	15,023	1,353	1,107,988	339,499	9,544	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	570	0	29,610	9,073	1,567	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,804	0	315,198	96,580	9,049	65.00
66.00	06600	PHYSICAL THERAPY	591	541	291,265	89,247	12,967	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	46	0	125,030	38,310	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	36,849	11,291	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,376	0	14,444	4,426	4,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,953	4,275	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,629	0	235,096	72,036	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
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	6,914	10,012	2,597,349	795,849	92,073	88.00
90.00	09000	CLINIC	400	2,165	501,315	153,608	22,098	90.00
91.00	09100	EMERGENCY	2,650	2,435	2,067,018	633,355	19,649	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
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,756	46,272	18,579,059	4,355,841	563,739	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	142	0	24,394	7,475	19,112	192.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	111,898	46,272	18,603,453	4,363,316	582,851	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	457,963					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,968				8.00
9.00	00900	HOUSEKEEPING	10,050	0	530,439			9.00
10.00	01000	DIETARY	11,356	2,424	52,507	166,098		10.00
11.00	01100	CAFETERIA	26,376	0	26,901	0	496,941	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,498	0	3,949	0	10,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	5,224	0	4,442	0	10,856	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,377	0	15,734	0	28,791	16.00
17.00	01700	SOCIAL SERVICE	553	0	0	0	4,615	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	52	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	139,937	51,626	143,206	166,098	110,391	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	106,986	12,373	83,542	0	25,015	50.00
53.00	05300	ANESTHESIOLOGY	620	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,721	12,865	11,600	0	15,366	54.00
57.00	05700	CT SCAN	9,353	3,394	13,266	0	17,568	57.00
58.00	05800	MRI	5,855	3,394	3,764	0	5,034	58.00
60.00	06000	LABORATORY	12,806	0	30,727	0	54,802	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,103	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	12,142	322	13,142	0	16,939	65.00
66.00	06600	PHYSICAL THERAPY	17,399	7,115	20,485	0	14,946	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,825	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,311	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,590	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	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
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	115,843	88.00
90.00	09000	CLINIC	29,652	802	24,742	0	11,904	90.00
91.00	09100	EMERGENCY	26,365	33,653	82,432	0	48,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	457,963	127,968	530,439	166,098	496,941	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	457,963	127,968	530,439	166,098	496,941	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
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	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	375,076				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	21,010			14.00
15.00	01500	PHARMACY	0	0	0	571,545		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	589,738	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	208,577	12,826	0	359,292	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	47,300	0	0	106,020	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	4,819	0	21,351	65.00
66.00	06600	PHYSICAL THERAPY	0	28,225	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	571,545	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	103,075	90.00
91.00	09100	EMERGENCY	0	90,974	3,365	0	0	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
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	375,076	21,010	571,545	589,738	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	375,076	21,010	571,545	589,738	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
						SERVICES-SALAR	SERVICES-OTHER	
						Y & FRINGES APPRV	PRGM COSTS APPRV	
			17.00	19.00	20.00	21.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	105,776					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	372,142				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	02301	PARAMED ED PRGM-(SPECIFY)	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	105,776	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	372,142	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,776	372,142	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments		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)	105,776	372,142	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	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	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	02301	PARAMED ED PRGM-(SPECIFY)	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,567,768	0	3,567,768		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,404,994	0	1,404,994		50.00
53.00	05300	ANESTHESIOLOGY	0	439,567	0	439,567		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,348,783	0	1,348,783		54.00
57.00	05700	CT SCAN	0	388,327	0	388,327		57.00
58.00	05800	MRI	0	237,713	0	237,713		58.00
60.00	06000	LABORATORY	0	1,555,366	0	1,555,366		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	42,353	0	42,353		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	489,542	0	489,542		65.00
66.00	06600	PHYSICAL THERAPY	0	481,649	0	481,649		66.00
66.01	06601	CARDIAC REHAB	0	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	168,165	0	168,165		67.00
68.00	06800	SPEECH PATHOLOGY	0	49,451	0	49,451		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	28,626	0	28,626		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,228	0	18,228		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	878,677	0	878,677		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0		76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0		76.01
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	3,601,114	0	3,601,114		88.00
90.00	09000	CLINIC	0	847,196	0	847,196		90.00
91.00	09100	EMERGENCY	0	3,004,953	0	3,004,953		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
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0	18,552,472	0	18,552,472		118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	50,981	0	50,981		192.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	18,603,453	0	18,603,453		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00580	ADMINISTRATIVE & GENERAL	0	13,055	0	13,055	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	4,288	0	4,288	0	5.02
5.03	01160	COMMUNICATIONS	0	0	0	0	0	5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL	0	35,100	35,427	70,527	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	97,507	0	97,507	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,602	1,179	6,781	0	9.00
10.00	01000	DIETARY	0	6,330	85	6,415	0	10.00
11.00	01100	CAFETERIA	0	14,703	414	15,117	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,950	0	1,950	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	2,912	0	2,912	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,687	895	10,582	0	16.00
17.00	01700	SOCIAL SERVICE	0	308	0	308	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	02301	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	78,005	16,242	94,247	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	59,638	83,711	143,349	0	50.00
53.00	05300	ANESTHESIOLOGY	0	346	17,126	17,472	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,206	36,089	44,295	0	54.00
57.00	05700	CT SCAN	0	5,214	45,576	50,790	0	57.00
58.00	05800	MRI	0	3,264	0	3,264	0	58.00
60.00	06000	LABORATORY	0	7,139	22,184	29,323	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,172	0	1,172	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,768	3,514	10,282	0	65.00
66.00	06600	PHYSICAL THERAPY	0	9,699	2,606	12,305	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,116	0	3,116	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	2,785	2,785	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
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	68,868	6,868	75,736	0	88.00
90.00	09000	CLINIC	0	16,529	1,778	18,307	0	90.00
91.00	09100	EMERGENCY	0	14,697	4,962	19,659	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
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	474,103	281,441	755,544	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,296	2,081	16,377	0	192.00
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)	0	488,399	283,522	771,921	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	PURCHASING RECEIVING AND STORES	COMMUNICATIONS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
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	00580	ADMINISTRATIVE & GENERAL	13,055					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	4,288				5.02
5.03	01160	COMMUNICATIONS	0	0	0			5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL	0	318	0	70,845		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	111	0	2,220	2,331	6.00
7.00	00700	OPERATION OF PLANT	0	1	0	1,248	521	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	487	0	8.00
9.00	00900	HOUSEKEEPING	0	121	0	1,953	30	9.00
10.00	01000	DIETARY	0	572	0	348	34	10.00
11.00	01100	CAFETERIA	0	0	0	1,615	79	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	7	0	1,350	10	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	80	0	14.00
15.00	01500	PHARMACY	0	764	0	2,084	16	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8	0	1,961	52	16.00
17.00	01700	SOCIAL SERVICE	0	2	0	382	2	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,417	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	452	92	0	8,247	417	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	886	308	0	3,595	319	50.00
53.00	05300	ANESTHESIOLOGY	107	53	0	253	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,518	157	0	4,887	44	54.00
57.00	05700	CT SCAN	1,757	40	0	1,286	28	57.00
58.00	05800	MRI	465	3	0	820	17	58.00
60.00	06000	LABORATORY	2,724	576	0	5,512	38	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	66	22	0	147	6	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	308	69	0	1,568	36	65.00
66.00	06600	PHYSICAL THERAPY	484	23	0	1,449	52	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	147	2	0	622	0	67.00
68.00	06800	SPEECH PATHOLOGY	16	0	0	183	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	148	53	0	72	17	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25	0	0	69	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	565	599	0	1,170	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,557	265	0	12,922	368	88.00
90.00	09000	CLINIC	264	15	0	2,494	88	90.00
91.00	09100	EMERGENCY	1,566	102	0	10,283	79	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,055	4,283	0	70,724	2,255	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5	0	121	76	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,055	4,288	0	70,845	2,331	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	99,277					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	487				8.00
9.00	00900	HOUSEKEEPING	2,179	0	11,064			9.00
10.00	01000	DIETARY	2,462	9	1,095	10,935		10.00
11.00	01100	CAFETERIA	5,718	0	561	0	23,090	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	758	0	82	0	490	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,133	0	93	0	504	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,767	0	328	0	1,338	16.00
17.00	01700	SOCIAL SERVICE	120	0	0	0	214	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	2	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,336	197	2,987	10,935	5,129	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,192	47	1,743	0	1,162	50.00
53.00	05300	ANESTHESIOLOGY	134	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,191	49	242	0	714	54.00
57.00	05700	CT SCAN	2,027	13	277	0	816	57.00
58.00	05800	MRI	1,269	13	79	0	234	58.00
60.00	06000	LABORATORY	2,776	0	641	0	2,546	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	456	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	2,632	1	274	0	787	65.00
66.00	06600	PHYSICAL THERAPY	3,772	27	427	0	694	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	224	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	61	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,212	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	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	5,385	88.00
90.00	09000	CLINIC	6,428	3	516	0	553	90.00
91.00	09100	EMERGENCY	5,715	128	1,719	0	2,237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	99,277	487	11,064	10,935	23,090	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	99,277	487	11,064	10,935	23,090	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			12.00	13.00	14.00	15.00	16.00	
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	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	4,647				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	80			14.00
15.00	01500	PHARMACY	0	0	0	7,506		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	18,036	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,584	49	0	10,989	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	586	0	0	3,242	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	18	0	653	65.00
66.00	06600	PHYSICAL THERAPY	0	350	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,506	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	3,152	90.00
91.00	09100	EMERGENCY	0	1,127	13	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,647	80	7,506	18,036	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,647	80	7,506	18,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			INTERNS & RESIDENTS					
			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	SERVICES-SALAR		SERVICES-OTHER
						Y & FRINGES APPRV		PRGM COSTS APPRV
			17.00	19.00	20.00	21.00	22.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	1,028					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,419				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	02301	PARAMED ED PRGM-(SPECIFY)	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,028					30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0					50.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
57.00	05700	CT SCAN	0					57.00
58.00	05800	MRI	0					58.00
60.00	06000	LABORATORY	0					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0					62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0					62.30
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
66.01	06601	CARDIAC REHAB	0					66.01
67.00	06700	OCCUPATIONAL THERAPY	0					67.00
68.00	06800	SPEECH PATHOLOGY	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0					76.00
76.01	03950	OCCUPATIONAL MEDICINE	0					76.01
76.97	07697	CARDIAC REHABILITATION	0					76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0					76.98
76.99	07699	LITHOTRIPSY	0					76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0					88.00
90.00	09000	CLINIC	0					90.00
91.00	09100	EMERGENCY	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0					93.99
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		1,028	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
200.00		Cross Foot Adjustments		1,419	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)	1,028	1,419	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	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	00580	ADMINISTRATIVE & GENERAL					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	01160	COMMUNICATIONS					5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL					5.04
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	02301	PARAMED ED PRGM-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		167,689	0	167,689	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		178,429	0	178,429	50.00
53.00	05300	ANESTHESIOLOGY		18,021	0	18,021	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		55,097	0	55,097	54.00
57.00	05700	CT SCAN		57,034	0	57,034	57.00
58.00	05800	MRI		6,164	0	6,164	58.00
60.00	06000	LABORATORY		44,136	0	44,136	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		1,869	0	1,869	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		16,628	0	16,628	65.00
66.00	06600	PHYSICAL THERAPY		19,583	0	19,583	66.00
66.01	06601	CARDIAC REHAB		0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		995	0	995	67.00
68.00	06800	SPEECH PATHOLOGY		260	0	260	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		4,618	0	4,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		94	0	94	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		12,625	0	12,625	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER		0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE		0	0	0	76.01
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		96,233	0	96,233	88.00
90.00	09000	CLINIC		31,820	0	31,820	90.00
91.00	09100	EMERGENCY		42,628	0	42,628	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	753,923	0	753,923	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES		16,579	0	16,579	192.00
200.00		Cross Foot Adjustments	0	1,419	0	1,419	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	771,921	0	771,921	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1344

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

Worksheet B-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (GROSS REVENUE)	PURCHASING RECEIVING AND STORES (COSTED REQUIS)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,159					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		283,641				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,746,186			4.00
5.01	00580	ADMINISTRATIVE & GENERAL	2,116	0	352,851	31,111,057		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	695	0	79,484	0	1,307,541	5.02
5.03	01160	COMMUNICATIONS	0	0	0	0	0	5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL	5,689	35,442	444,796	0	97,131	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	189,614	0	33,850	6.00
7.00	00700	OPERATION OF PLANT	15,804	0	0	0	382	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	908	1,179	263,541	0	36,849	9.00
10.00	01000	DIETARY	1,026	85	20,452	0	174,473	10.00
11.00	01100	CAFETERIA	2,383	414	181,853	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	316	0	195,346	0	2,014	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	472	0	229,434	0	233,265	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,570	895	242,514	0	2,472	16.00
17.00	01700	SOCIAL SERVICE	50	0	57,390	0	696	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	207,645	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,643	16,249	1,125,036	1,076,780	27,965	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,666	83,748	256,538	2,108,715	93,958	50.00
53.00	05300	ANESTHESIOLOGY	56	17,133	0	255,737	16,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,330	36,104	372,091	3,614,212	47,786	54.00
57.00	05700	CT SCAN	845	45,595	0	4,182,273	12,057	57.00
58.00	05800	MRI	529	0	0	1,107,406	1,014	58.00
60.00	06000	LABORATORY	1,157	22,193	488,221	6,514,110	175,540	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	190	0	0	157,304	6,657	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,097	3,515	194,686	732,826	21,079	65.00
66.00	06600	PHYSICAL THERAPY	1,572	2,607	183,999	1,151,595	6,911	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	88,228	348,878	542	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	27,355	39,129	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	505	0	0	351,798	16,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,659	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,786	0	1,344,251	182,623	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
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	11,162	6,871	1,691,440	3,707,845	80,786	88.00
90.00	09000	CLINIC	2,679	1,779	346,170	629,014	4,679	90.00
91.00	09100	EMERGENCY	2,382	4,964	507,502	3,729,525	30,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,842	281,559	7,746,186	31,111,057	1,305,881	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,317	2,082	0	0	1,660	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	488,399	283,522	2,410,094	781,464	111,898	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.169848	0.999580	0.311133	0.025119	0.085579	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	13,055	4,288	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000420	0.003279	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1344

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

Worksheet B-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMINISTRATIVE & GENERAL (GROSS REVENUE)	PURCHASING RECEIVING AND STORES (COSTED REQUIS)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5.01	5.02	
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: 14-1344

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

Worksheet B-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		COMMUNICATIONS (PHONES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5A.04	5.04	6.00	7.00	
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	00500	ADMINISTRATIVE & GENERAL					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	01160	COMMUNICATIONS	171				5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL	19	-4,363,316	14,240,137		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	446,147	70,659	6.00
7.00	00700	OPERATION OF PLANT	4	0	250,763	15,804	41,376
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	97,954	0	0
9.00	00900	HOUSEKEEPING	1	0	392,602	908	908
10.00	01000	DIETARY	5	0	69,923	1,026	1,026
11.00	01100	CAFETERIA	0	0	324,559	2,383	2,383
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	3	0	271,340	316	316
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	16,082	0	0
15.00	01500	PHARMACY	2	0	418,804	472	472
16.00	01600	MEDICAL RECORDS & LIBRARY	14	0	394,122	1,570	1,570
17.00	01700	SOCIAL SERVICE	4	0	76,696	50	50
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	284,819	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29	0	1,657,787	12,643	12,643
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18	0	722,610	9,666	9,666
53.00	05300	ANESTHESIOLOGY	1	0	50,783	56	56
54.00	05400	RADIOLOGY-DIAGNOSTIC	8	0	982,280	1,330	1,330
57.00	05700	CT SCAN	1	0	258,553	845	845
58.00	05800	MRI	1	0	164,804	529	529
60.00	06000	LABORATORY	5	0	1,107,988	1,157	1,157
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	29,610	190	190
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	315,198	1,097	1,097
66.00	06600	PHYSICAL THERAPY	2	0	291,265	1,572	1,572
66.01	06601	CARDIAC REHAB	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	125,030	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	36,849	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14,444	505	505
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	13,953	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	235,096	0	0
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	37	0	2,597,349	11,162	0
90.00	09000	CLINIC	8	0	501,315	2,679	2,679
91.00	09100	EMERGENCY	9	0	2,067,018	2,382	2,382
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171	-4,363,316	14,215,743	68,342	41,376
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	24,394	2,317	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	46,272		4,363,316	582,851	457,963
203.00		Unit cost multiplier (Wkst. B, Part I)	270.596491		0.306410	8.248786	11.068325
204.00		Cost to be allocated (per Wkst. B, Part II)	0		70,845	2,331	99,277
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.004975	0.032989	2.399386
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1344

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

Worksheet B-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		8.00	9.00	10.00	11.00	12.00	
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	00580	ADMINISTRATIVE & GENERAL					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	01160	COMMUNICATIONS					5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,787				8.00
9.00	00900	HOUSEKEEPING	0	8,597			9.00
10.00	01000	DIETARY	1,000	851	5,136		10.00
11.00	01100	CAFETERIA	0	436	0	9,476	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	64	0	201	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	72	0	207	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	255	0	549	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	88	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,295	2,321	5,136	2,105	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,104	1,354	0	477	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,307	188	0	293	54.00
57.00	05700	CT SCAN	1,400	215	0	335	57.00
58.00	05800	MRI	1,400	61	0	96	58.00
60.00	06000	LABORATORY	0	498	0	1,045	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	133	213	0	323	65.00
66.00	06600	PHYSICAL THERAPY	2,935	332	0	285	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	92	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	25	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	76.01
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	2,209	88.00
90.00	09000	CLINIC	331	401	0	227	90.00
91.00	09100	EMERGENCY	13,882	1,336	0	918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,787	8,597	5,136	9,476	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	127,968	530,439	166,098	496,941	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.424233	61.700477	32.339953	52.442064	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	487	11,064	10,935	23,090	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009226	1.286961	2.129089	2.436682	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: 14-1344

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

Worksheet B-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
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	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	78,735					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,082				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	801		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	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	02301	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,784	9,817	0	488	100	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,929	0	0	144	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,689	0	29	0	65.00
66.00	06600	PHYSICAL THERAPY	5,925	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	140	0	90.00
91.00	09100	EMERGENCY	19,097	2,576	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	78,735	16,082	100	801	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	375,076	21,010	571,545	589,738	105,776	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.763777	1.306430	5,715.450000	736.252185	1,057.760000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,647	80	7,506	18,036	1,028	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.059021	0.004975	75.060000	22.516854	10.280000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1344

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

Worksheet B-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	13.00	14.00	15.00	16.00	17.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1344

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

Worksheet B-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)	
					SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			19.00	20.00	21.00	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	00580	ADMINISTRATIVE & GENERAL						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	01160	COMMUNICATIONS						5.03
5.04	00591	OTHER ADMINISTRATIVE AND GENERAL						5.04
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	100					19.00
20.00	02000	NURSING SCHOOL		0				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	02301	PARAMED ED PRGM-(SPECIFY)					0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	100	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	372,142	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,721.420000	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,419	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.190000	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1344

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

Worksheet B-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	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		
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	19.00	20.00	0		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000			0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,567,768		3,567,768	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,404,994		1,404,994	0	0	50.00
53.00	05300	ANESTHESIOLOGY	439,567		439,567	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,348,783		1,348,783	0	0	54.00
57.00	05700	CT SCAN	388,327		388,327	0	0	57.00
58.00	05800	MRI	237,713		237,713	0	0	58.00
60.00	06000	LABORATORY	1,555,366		1,555,366	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,353		42,353	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	489,542	0	489,542	0	0	65.00
66.00	06600	PHYSICAL THERAPY	481,649	0	481,649	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	168,165	0	168,165	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	49,451	0	49,451	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,626		28,626	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,228		18,228	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	878,677		878,677	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0		0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,601,114		3,601,114	0	0	88.00
90.00	09000	CLINIC	847,196		847,196	0	0	90.00
91.00	09100	EMERGENCY	3,004,953		3,004,953	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	685,542		685,542	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
200.00		Subtotal (see instructions)	19,238,014	0	19,238,014	0	0	200.00
201.00		Less Observation Beds	685,542		685,542			201.00
202.00		Total (see instructions)	18,552,472	0	18,552,472	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

			Title XVIII			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	856,817		856,817			30.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	172,585	1,936,130	2,108,715	0.666280	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	16,952	238,785	255,737	1.718824	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	158,948	3,455,264	3,614,212	0.373189	0.000000	54.00	
57.00	05700	CT SCAN	217,897	3,964,376	4,182,273	0.092851	0.000000	57.00	
58.00	05800	MRI	26,074	1,081,332	1,107,406	0.214657	0.000000	58.00	
60.00	06000	LABORATORY	358,950	6,155,160	6,514,110	0.238769	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	94,305	62,999	157,304	0.269243	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	309,996	422,830	732,826	0.668019	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	126,980	1,024,615	1,151,595	0.418245	0.000000	66.00	
66.01	06601	CARDIAC REHAB	0	0	0	0.000000	0.000000	66.01	
67.00	06700	OCCUPATIONAL THERAPY	70,060	278,818	348,878	0.482017	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	14,392	24,737	39,129	1.263794	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	291,377	60,421	351,798	0.081371	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	59,659	59,659	0.305536	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	655,317	688,934	1,344,251	0.653655	0.000000	73.00	
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00	
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0.000000	0.000000	76.01	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	83,556	3,624,289	3,707,845			88.00	
90.00	09000	CLINIC	30,522	598,492	629,014	1.346864	0.000000	90.00	
91.00	09100	EMERGENCY	3,295	3,726,230	3,729,525	0.805720	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,000	218,963	219,963	3.116624	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
200.00		Subtotal (see instructions)	3,489,023	27,622,034	31,111,057			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	3,489,023	27,622,034	31,111,057			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
66.01	06601 CARDIAC REHAB	0.000000			66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
76.01	03950 OCCUPATIONAL MEDICINE	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

			Title XIX		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	3,567,768		3,567,768	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,404,994		1,404,994	0	0	50.00
53.00	05300	ANESTHESIOLOGY	439,567		439,567	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,348,783		1,348,783	0	0	54.00
57.00	05700	CT SCAN	388,327		388,327	0	0	57.00
58.00	05800	MRI	237,713		237,713	0	0	58.00
60.00	06000	LABORATORY	1,555,366		1,555,366	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	42,353		42,353	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	489,542	0	489,542	0	0	65.00
66.00	06600	PHYSICAL THERAPY	481,649	0	481,649	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	168,165	0	168,165	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	49,451	0	49,451	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,626		28,626	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,228		18,228	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	878,677		878,677	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0		0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,601,114		3,601,114	0	0	88.00
90.00	09000	CLINIC	847,196		847,196	0	0	90.00
91.00	09100	EMERGENCY	3,004,953		3,004,953	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	685,542		685,542	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
200.00		Subtotal (see instructions)	19,238,014	0	19,238,014	0	0	200.00
201.00		Less Observation Beds	685,542		685,542			201.00
202.00		Total (see instructions)	18,552,472	0	18,552,472	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	856,817		856,817			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	172,585	1,936,130	2,108,715	0.666280	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	16,952	238,785	255,737	1.718824	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	158,948	3,455,264	3,614,212	0.373189	0.000000	54.00
57.00	05700	CT SCAN	217,897	3,964,376	4,182,273	0.092851	0.000000	57.00
58.00	05800	MRI	26,074	1,081,332	1,107,406	0.214657	0.000000	58.00
60.00	06000	LABORATORY	358,950	6,155,160	6,514,110	0.238769	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	94,305	62,999	157,304	0.269243	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	309,996	422,830	732,826	0.668019	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	126,980	1,024,615	1,151,595	0.418245	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	70,060	278,818	348,878	0.482017	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,392	24,737	39,129	1.263794	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	291,377	60,421	351,798	0.081371	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	59,659	59,659	0.305536	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	655,317	688,934	1,344,251	0.653655	0.000000	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0.000000	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	83,556	3,624,289	3,707,845	0.971215	0.000000	88.00
90.00	09000	CLINIC	30,522	598,492	629,014	1.346864	0.000000	90.00
91.00	09100	EMERGENCY	3,295	3,726,230	3,729,525	0.805720	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,000	218,963	219,963	3.116624	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
200.00		Subtotal (see instructions)	3,489,023	27,622,034	31,111,057			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,489,023	27,622,034	31,111,057			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
66.01	06601 CARDIAC REHAB	0.000000			66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000			76.00
76.01	03950 OCCUPATIONAL MEDICINE	0.000000			76.01
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	178,429	2,108,715	0.084615	87,185	7,377	50.00	
53.00	05300	ANESTHESIOLOGY	18,021	255,737	0.070467	4,919	347	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,097	3,614,212	0.015245	89,447	1,364	54.00	
57.00	05700	CT SCAN	57,034	4,182,273	0.013637	89,811	1,225	57.00	
58.00	05800	MRI	6,164	1,107,406	0.005566	10,594	59	58.00	
60.00	06000	LABORATORY	44,136	6,514,110	0.006775	249,111	1,688	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,869	157,304	0.011881	24,326	289	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	16,628	732,826	0.022690	135,135	3,066	65.00	
66.00	06600	PHYSICAL THERAPY	19,583	1,151,595	0.017005	39,647	674	66.00	
66.01	06601	CARDIAC REHAB	0	0	0.000000	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	995	348,878	0.002852	24,184	69	67.00	
68.00	06800	SPEECH PATHOLOGY	260	39,129	0.006645	6,622	44	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,618	351,798	0.013127	187,758	2,465	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	94	59,659	0.001576	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	12,625	1,344,251	0.009392	340,147	3,195	73.00	
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00	
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0.000000	0	0	76.01	
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	96,233	3,707,845	0.025954	0	0	88.00	
90.00	09000	CLINIC	31,820	629,014	0.050587	20	1	90.00	
91.00	09100	EMERGENCY	42,628	3,729,525	0.011430	2,618	30	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,221	219,963	0.146484	910	133	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99	
200.00		Total (lines 50 through 199)	618,455	30,254,240		1,292,434	22,026	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1344

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	40,616	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
200.00		Total (lines 50 through 199)	40,616	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1344

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			Title XVIII		Hospital	Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)
			4.00	5.00	6.00	7.00	8.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,108,715	0.000000
53.00	05300	ANESTHESIOLOGY	0	40,616	0	255,737	0.158819
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,614,212	0.000000
57.00	05700	CT SCAN	0	0	0	4,182,273	0.000000
58.00	05800	MRI	0	0	0	1,107,406	0.000000
60.00	06000	LABORATORY	0	0	0	6,514,110	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	157,304	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	732,826	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	1,151,595	0.000000
66.01	06601	CARDIAC REHAB	0	0	0	0	0.000000
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	348,878	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	39,129	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	351,798	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,659	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,344,251	0.000000
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,707,845	0.000000
90.00	09000	CLINIC	0	0	0	629,014	0.000000
91.00	09100	EMERGENCY	0	0	0	3,729,525	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	219,963	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000
200.00		Total (lines 50 through 199)	0	40,616	0	30,254,240	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/27/2021 4:30 pm

				Title XVIII		Hospital		Cost	
Cost Center Description			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
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	87,185	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	4,919	781	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	89,447	0	0	0	54.00	
57.00	05700	CT SCAN	0.000000	89,811	0	0	0	57.00	
58.00	05800	MRI	0.000000	10,594	0	0	0	58.00	
60.00	06000	LABORATORY	0.000000	249,111	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	24,326	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	135,135	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	39,647	0	0	0	66.00	
66.01	06601	CARDIAC REHAB	0.000000	0	0	0	0	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	24,184	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	6,622	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	187,758	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	340,147	0	0	0	73.00	
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00	
76.01	03950	OCCUPATIONAL MEDICINE	0.000000	0	0	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	0.000000	20	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	2,618	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	910	0	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
200.00		Total (lines 50 through 199)		1,292,434	781	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/27/2021 4:30 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.666280	0	1,083,282	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.718824	0	238,062	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.373189	0	1,068,451	0	0	54.00
57.00	05700	CT SCAN	0.092851	0	1,203,226	0	0	57.00
58.00	05800	MRI	0.214657	0	386,782	0	0	58.00
60.00	06000	LABORATORY	0.238769	0	2,305,890	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.269243	0	26,766	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.668019	0	157,282	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.418245	0	420,478	0	0	66.00
66.01	06601	CARDIAC REHAB	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.482017	0	114,495	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.263794	0	3,293	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.081371	0	45,895	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.305536	0	49,852	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.653655	0	460,337	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	1.346864	0	71,881	0	0	90.00
91.00	09100	EMERGENCY	0.805720	0	1,027,289	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3.116624	0	111,877	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	8,775,138	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	8,775,138	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1344		Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 1/27/2021 4:30 pm
			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	721,769	0		50.00
53.00	05300	ANESTHESIOLOGY	409,187	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	398,734	0		54.00
57.00	05700	CT SCAN	111,721	0		57.00
58.00	05800	MRI	83,025	0		58.00
60.00	06000	LABORATORY	550,575	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,207	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	105,067	0		65.00
66.00	06600	PHYSICAL THERAPY	175,863	0		66.00
66.01	06601	CARDIAC REHAB	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	55,189	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,162	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,735	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,232	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	300,902	0		73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	96,814	0		90.00
91.00	09100	EMERGENCY	827,707	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	348,679	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	4,215,568	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,215,568	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

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		167,689	36,725	130,964	1,134	115.49	30.00
200.00	Total (lines 30 through 199)		167,689		130,964	1,134		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		29	3,349				
200.00	Total (lines 30 through 199)		29	3,349				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		Title XIX		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	178,429	2,108,715	0.084615	0	50.00
53.00	05300	ANESTHESIOLOGY	18,021	255,737	0.070467	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,097	3,614,212	0.015245	0	54.00
57.00	05700	CT SCAN	57,034	4,182,273	0.013637	0	57.00
58.00	05800	MRI	6,164	1,107,406	0.005566	0	58.00
60.00	06000	LABORATORY	44,136	6,514,110	0.006775	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,869	157,304	0.011881	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	16,628	732,826	0.022690	0	65.00
66.00	06600	PHYSICAL THERAPY	19,583	1,151,595	0.017005	0	66.00
66.01	06601	CARDIAC REHAB	0	0	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	995	348,878	0.002852	0	67.00
68.00	06800	SPEECH PATHOLOGY	260	39,129	0.006645	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,618	351,798	0.013127	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	94	59,659	0.001576	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,625	1,344,251	0.009392	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0.000000	0	76.01
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	96,233	3,707,845	0.025954	0	88.00
90.00	09000	CLINIC	31,820	629,014	0.050587	0	90.00
91.00	09100	EMERGENCY	42,628	3,729,525	0.011430	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	32,221	219,963	0.146484	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	93.99
200.00		Total (lines 50 through 199)	618,455	30,254,240		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1344		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 1/27/2021 4:30 pm		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	1,134	0.00			29	30.00	
200.00		Total (lines 30 through 199)	0	0	1,134				29	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	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description			Title XIX		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	372,142	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0 76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
200.00		Total (lines 50 through 199)	372,142	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1344		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/27/2021 4:30 pm	
			Title XIX		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	2,108,715	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	372,142	0	255,737	1.455175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,614,212	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	4,182,273	0.000000	57.00
58.00	05800	MRI	0	0	0	1,107,406	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	6,514,110	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	157,304	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	732,826	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,151,595	0.000000	66.00
66.01	06601	CARDIAC REHAB	0	0	0	0	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	348,878	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	39,129	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	351,798	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,659	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,344,251	0.000000	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0	0	0	0	0.000000	76.01
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	3,707,845	0.000000	88.00
90.00	09000	CLINIC	0	0	0	629,014	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	3,729,525	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	219,963	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	372,142	0	30,254,240		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1344

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	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	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	06601	CARDIAC REHAB	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.01	03950	OCCUPATIONAL MEDICINE	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/27/2021 4:30 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,452	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,134	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)			855	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			159	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)			159	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)			594	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)			156	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)			156	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)			3,567,768	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)			781,371	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,786,397	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)			2,786,397	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)			2,457.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,459,541	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,459,541	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1344

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

Worksheet D-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					546,039	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,005,580	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)					383,314	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					383,314	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					766,628	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)					279	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,457.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					685,542	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1344

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

Worksheet D-1

Date/Time Prepared:
1/27/2021 4:30 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	167,689	3,567,768	0.047001	685,542	32,221	90.00
91.00	Nursing School cost	0	3,567,768	0.000000	685,542	0	91.00
92.00	Allied health cost	0	3,567,768	0.000000	685,542	0	92.00
93.00	All other Medical Education	0	3,567,768	0.000000	685,542	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1344

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

Worksheet D-1

Date/Time Prepared:
1/27/2021 4:30 pm

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,452	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,134	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)	855	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	159	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)	159	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)	29	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	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)	3,567,768	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)	781,371	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,786,397	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)	2,786,397	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)	2,457.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	71,257	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)	71,257	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1344

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

Worksheet D-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					71,257	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					279	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,457.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					685,542	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1344

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

Worksheet D-1

Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	167,689	3,567,768	0.047001	685,542	32,221	90.00
91.00	Nursing School cost	0	3,567,768	0.000000	685,542	0	91.00
92.00	Allied health cost	0	3,567,768	0.000000	685,542	0	92.00
93.00	All other Medical Education	0	3,567,768	0.000000	685,542	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/27/2021 4:30 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		512,626		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.666280	87,185	58,090	50.00
53.00	05300 ANESTHESIOLOGY	1.718824	4,919	8,455	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.373189	89,447	33,381	54.00
57.00	05700 CT SCAN	0.092851	89,811	8,339	57.00
58.00	05800 MRI	0.214657	10,594	2,274	58.00
60.00	06000 LABORATORY	0.238769	249,111	59,480	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.269243	24,326	6,550	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.668019	135,135	90,273	65.00
66.00	06600 PHYSICAL THERAPY	0.418245	39,647	16,582	66.00
66.01	06601 CARDIAC REHAB	0.000000	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.482017	24,184	11,657	67.00
68.00	06800 SPEECH PATHOLOGY	1.263794	6,622	8,369	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.081371	187,758	15,278	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.305536	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.653655	340,147	222,339	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03950 OCCUPATIONAL MEDICINE	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.346864	20	27	90.00
91.00	09100 EMERGENCY	0.805720	2,618	2,109	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3.116624	910	2,836	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,292,434	546,039	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,292,434		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1344 Component CCN: 14-Z344	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/27/2021 4:30 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.666280	12,136	8,086	50.00
53.00	05300 ANESTHESIOLOGY	1.718824	529	909	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.373189	17,281	6,449	54.00
57.00	05700 CT SCAN	0.092851	28,293	2,627	57.00
58.00	05800 MRI	0.214657	5,297	1,137	58.00
60.00	06000 LABORATORY	0.238769	58,490	13,966	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.269243	1,526	411	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.668019	57,565	38,455	65.00
66.00	06600 PHYSICAL THERAPY	0.418245	64,172	26,840	66.00
66.01	06601 CARDIAC REHAB	0.000000	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.482017	35,849	17,280	67.00
68.00	06800 SPEECH PATHOLOGY	1.263794	5,240	6,622	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.081371	71,177	5,792	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.305536	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.653655	187,408	122,500	73.00
76.00	03020 OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.01	03950 OCCUPATIONAL MEDICINE	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.346864	0	0	90.00
91.00	09100 EMERGENCY	0.805720	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3.116624	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)		544,963	251,074	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)		544,963		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/27/2021 4:30 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,215,568	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)		4,215,568	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		4,257,724	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)		38,750	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,253,617	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,965,357	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,965,357	30.00
31.00	Primary payer payments		164	31.00
32.00	Subtotal (line 30 minus line 31)		2,965,193	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)		120,303	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		78,197	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		25,573	36.00
37.00	Subtotal (see instructions)		3,043,390	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,043,390	40.00
40.01	Sequestration adjustment (see instructions)		50,825	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,740,862	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)		1,251,703	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: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
1/27/2021 4:30 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,041,216		1,693,662	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	01/16/2020	47,200	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		47,200	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,041,216		1,740,862	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		815,347		1,251,703	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,856,563		2,992,565	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: 14-1344

Period:

Worksheet E-1

Component CCN: 14-Z344

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
1/27/2021 4:30 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		570,256		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)		570,256		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		429,630		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		999,886		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: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
1/27/2021 4:30 pm

		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: 14-1344 Component CCN: 14-Z344	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2 Date/Time Prepared: 1/27/2021 4:30 pm	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		774,294	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)		253,585	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		312	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)		1,027,879	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,027,879	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)		1,027,879	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		11,011	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,016,868	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,016,868	0	19.00
19.01	Sequestration adjustment (see instructions)		16,982	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		570,256	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)		429,630	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: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 1/27/2021 4:30 pm
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,005,580	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)		2,005,580	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,025,636	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)		2,025,636	19.00
20.00	Deductibles (exclude professional component)		149,336	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,876,300	22.00
23.00	Coinsurance		2,816	23.00
24.00	Subtotal (line 22 minus line 23)		1,873,484	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		22,477	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		14,610	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,838	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,888,094	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		1,888,094	30.00
30.01	Sequestration adjustment (see instructions)		31,531	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,041,216	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)		815,347	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: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 1/27/2021 4:30 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	71,257			1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	71,257		0	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	71,257		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	0		0	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0		0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	0		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	71,257		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	71,257		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0			28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	71,257		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	71,257		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	71,257		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	71,257		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	71,257		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	71,257		0	40.00
41.00	Interim payments	66,734		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	4,523		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

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

Provider CCN: 14-1344

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

Worksheet G

Date/Time Prepared:
1/27/2021 4:30 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,053,241	0	0	0	1.00
2.00	Temporary investments	253,617	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,581,663	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,048,700	0	0	0	6.00
7.00	Inventory	335,492	0	0	0	7.00
8.00	Prepaid expenses	173,644	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,348,957	0	0	0	11.00
FIXED ASSETS						
12.00	Land	20,150	0	0	0	12.00
13.00	Land improvements	571,703	0	0	0	13.00
14.00	Accumulated depreciation	-403,117	0	0	0	14.00
15.00	Buildings	9,285,207	0	0	0	15.00
16.00	Accumulated depreciation	-5,122,736	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	512,010	0	0	0	19.00
20.00	Accumulated depreciation	-304,954	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	3,399,891	0	0	0	23.00
24.00	Accumulated depreciation	-2,681,113	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,261,695	0	0	0	27.00
28.00	Accumulated depreciation	-1,199,679	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)	5,339,057	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	93,517	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	93,517	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	14,781,531	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	985,180	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,106,147	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	104,470	0	0	0	40.00
41.00	Deferred income	2,885,561	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,081,358	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	151,164	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	151,164	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,232,522	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,549,009	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)	9,549,009	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	14,781,531	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1344

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

Worksheet G-1

Date/Time Prepared:
1/27/2021 4:30 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,420,365		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		144,835				2.00
3.00	Total (sum of line 1 and line 2)		9,565,200		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TEMPORARILY RESTRICTED	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)		9,565,200		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TEMPORARILY RESTRICTED	16,191		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)		16,191		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,549,009		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	TEMPORARILY RESTRICTED		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	TEMPORARILY 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: 14-1344

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
1/27/2021 4:30 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	743,115		743,115	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	138,166		138,166	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	881,281		881,281	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)	881,281		881,281	17.00
18.00	Ancillary services	2,607,071	25,955,423	28,562,494	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	83,556	3,624,289	3,707,845	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,571,908	29,579,712	33,151,620	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,325,472		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		18,325,472		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1344

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

Worksheet G-3

Date/Time Prepared:
1/27/2021 4:30 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,151,620	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,274,661	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,876,959	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,325,472	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,448,513	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	19,542	6.00
7.00	Income from investments	7,021	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	110,454	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,428	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER GRANS, PURCH DISC, RENT INCOM	3,422,152	24.00
24.01	UNREALIZED GAINS ON INVESTMENTS	12,474	24.01
24.02	ASSETS RELEASED FORM RESTRICTIONS	19,542	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	3,595,613	25.00
26.00	Total (line 5 plus line 25)	147,100	26.00
27.00	TRANSFER TO RESTRICTED	2,265	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2,265	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	144,835	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1344

Period:

Worksheet M-1

Component CCN: 14-3499

From 07/01/2019

Date/Time Prepared:

To 06/30/2020

1/27/2021 4:30 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	379,624	0	379,624	0	379,624
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	497,627	0	497,627	0	497,627
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	778,536	0	778,536	0	778,536
10.00	Subtotal (sum of lines 1 through 9)	1,655,787	0	1,655,787	0	1,655,787
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	36,510	36,510	0	36,510
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	30,176	30,176	0	30,176
19.00	Other Health Care Costs	0	24,068	24,068	0	24,068
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	90,754	90,754	0	90,754
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,655,787	90,754	1,746,541	0	1,746,541
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	11,555	11,555	0	11,555
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	35,653	0	35,653	0	35,653
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)	35,653	11,555	47,208	0	47,208
FACILITY OVERHEAD						
29.00	Facility Costs	0	17,393	17,393	12,962	30,355
30.00	Administrative Costs	0	94,435	94,435	0	94,435
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	111,828	111,828	12,962	124,790
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,691,440	214,137	1,905,577	12,962	1,918,539

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1344

Period:

Worksheet M-1

Component CCN: 14-3499

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/27/2021 4:30 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-33,252	346,372	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	497,627	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	778,536	9.00
10.00	Subtotal (sum of lines 1 through 9)	-33,252	1,622,535	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	36,510	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	30,176	18.00
19.00	Other Health Care Costs	0	24,068	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	90,754	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-33,252	1,713,289	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	11,555	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	35,653	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	47,208	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	30,355	29.00
30.00	Administrative Costs	0	94,435	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	124,790	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-33,252	1,885,287	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1344

Period:

Worksheet M-2

Component CCN: 14-3499

From 07/01/2019
To 06/30/2020Date/Time Prepared:
1/27/2021 4:30 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.70	6,959	4,200	7,140		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	5.15	15,998	2,100	10,815		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.85	22,957		17,955	22,957	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)	6.85	22,957			22,957	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,713,289	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					47,208	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,760,497	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.973185	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					124,790	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,715,827	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,840,617	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,840,617	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,791,261	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,504,550	20.00

Health Financial Systems		LAWRENCE COUNTY MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1344	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN: 14-3499		Date/Time Prepared: 1/27/2021 4:30 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,504,550	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			18,234	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,486,316	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			22,957	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)			22,957	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			151.86	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)		151.86	151.86	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		2,157	2,157	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		327,562	327,562	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	655,124	16.00
16.01	Total program charges (see instructions)(from contractor's records)			709,526	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			29,749	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			27,468	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.)			450,086	16.04
16.05	Total program cost (see instructions)		0	477,554	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			65,049	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			112,927	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			477,554	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			11,053	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			488,607	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			488,607	26.00
26.01	Sequestration adjustment (see instructions)			8,160	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			384,395	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)			96,052	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: 14-1344 Component CCN: 14-3499	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 1/27/2021 4:30 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,622,535	1,622,535	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.002063	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	3,347	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	5,567	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	8,914	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,713,289	1,713,289	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,791,261	1,791,261	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.005203	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	9,320	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	18,234	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	353	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	51.65	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	214	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	11,053	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)			18,234	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)			11,053	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1344 Component CCN: 14-3499	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 1/27/2021 4:30 pm	
			RHC I	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		384,395	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)		384,395		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		96,052		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		480,447		7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00