

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1349	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 11/25/2020 8:47 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/25/2020	Time: 8:47 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 06101 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 SPARTA COMMUNITY HOSPITAL (14-1349) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-32,263	-514,608	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-203,967	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-68,283		0	10.00
200.00	Total	0	-236,230	-582,890	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1349		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 8:47 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 818 EAST BROADWAY			PO Box:				1.00		
2.00	City: SPARTA			State: IL		Zip Code: 62286		County: RANDOLPH		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		SPARTA COMMUNITY HHA	147694	99914		08/07/1998	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020		
21.00	Type of Control (see instructions)						11			
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1349

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

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		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	N	N	0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
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)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	Y	N
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			434,129	0	0	118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N			122.00
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 8:47 am	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						Zip Code	
						3.00	
						CBSA	
						4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1349	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 11/25/2020 8:47 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1349		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part II Date/Time Prepared: 11/25/2020 8:47 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N	N				6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/14/2020	Y	10/14/2020		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
11/25/2020 8:47 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL		41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	211 N BROADWAY STE 600, ST LOUIS, MO		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1349

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 8:47 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	21,655.00	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	21,655.00	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	21,655.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 8:47 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	595	13	916		1.00
2.00	HMO and other (see instructions)	80	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	675	0	909		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	53		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,270	13	1,878		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,270	13	1,878	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	4,949	0	8,797	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
24.10	HOSPICE (non-distinct part)			18		24.10
25.00	CMHC - CMHC					25.00
26.00	RHC (CONSOLIDATED)	11,958	0	44,203	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	27.00
28.00	Observation Bed Days		4	534		28.00
29.00	Ambulance Trips	0				29.00
30.00	Employee discount days (see instruction)			3		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: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
11/25/2020 8:47 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	183	4	288	1.00
2.00 HMO and other (see instructions)			22	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	183	4	288	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-1349 Component CCN: 14-7694		Period: From 07/01/2019 To 06/30/2020		Worksheet S-4 Date/Time Prepared: 11/25/2020 8:47 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	259.00	53.00	223.00	535.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			2.19	0.00	2.19	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			4.77	0.00	4.77	6.00
7.00	Nursing Supervisor			1.21	0.00	1.21	7.00
8.00	Physical Therapy Service			3.29	0.00	3.29	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.35	0.00	0.35	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.12	0.12	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	16060					20.00
20.01		41180					20.01
20.02		99914					20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,289	125	36	25	2,475	21.00
22.00	Skilled Nursing Visit Charges	745,649	40,491	12,559	8,646	807,345	22.00
23.00	Physical Therapy Visits	1,984	172	5	27	2,188	23.00
24.00	Physical Therapy Visit Charges	520,642	44,422	1,555	7,531	574,150	24.00
25.00	Occupational Therapy Visits	150	62	0	2	214	25.00
26.00	Occupational Therapy Visit Charges	48,804	20,290	0	655	69,749	26.00
27.00	Speech Pathology Visits	30	42	0	0	72	27.00
28.00	Speech Pathology Visit Charges	9,818	13,745	0	0	23,563	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,453	401	41	54	4,949	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,324,913	118,948	14,114	16,832	1,474,807	35.00
36.00	Total Number of Episodes (standard/non outlier)	353		19	7	379	36.00
37.00	Total Number of Outlier Episodes		16		0	16	37.00
38.00	Total Non-Routine Medical Supply Charges	18,008	1,959	281	24	20,272	38.00

Health Financial Systems		SPARTA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1349 Component CCN: 14-3464		Period: From 07/01/2019 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 11/25/2020 8:47 am		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	1300 NORTH MARKET				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	SPARTA		IL 62286	2.00	
		1.00				
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0				3.00
		Grant Award		Date		
		1.00		2.00		
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00	
		Sunday		Monday	Tuesday	
		from	to	from	to	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	CLINIC	09:00	14:00	09:00	19:00	11.00
		1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		6	13.00	
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number	WOMENS HEALTH CLINIC		143464	14.00	
14.01		COULTERVILLE MEDICAL CLINIC		143465	14.01	
14.02		FAMILY HEALTH CLINIC		143466	14.02	
14.03		STEELEVILLE CLINIC		143467	14.03	
14.04		MARISSA MEDICAL CLINIC		143490	14.04	
14.05		SPARTA MEDICAL OFFICE		143489	14.05	
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00
		County				
		4.00				
2.00	City, State, ZIP Code, County	RANDOLPH			2.00	

MCRIF32 - 16.4.169.4

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1349	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 11/25/2020 8:47 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.391866 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	4,763,836		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,509,410		5.00
6.00	Medicaid charges	11,613,581		6.00
7.00	Medicaid cost (line 1 times line 6)	4,550,968		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)	0		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	139,167		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0		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)	80,010	268,770	348,780 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	31,353	268,770	300,123 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	31,353	268,770	300,123 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)	3,019,312		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	327,880		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	504,431		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,514,881		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,162,047		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,462,170		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,462,170		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1349

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

Worksheet A

Date/Time Prepared:
11/25/2020 8:47 am

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		625,395	625,395	-109,547	515,848	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	176,067	176,067	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		932,688	932,688	30,060	962,748	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,754,837	5,754,837	0	5,754,837	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,370,637	2,715,015	6,085,652	-11,443	6,074,209	5.00
6.00	00600	MAINTENANCE & REPAIRS	240,112	3,765	243,877	0	243,877	6.00
7.00	00700	OPERATION OF PLANT	0	641,145	641,145	6,916	648,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	41,908	41,908	0	41,908	8.00
9.00	00900	HOUSEKEEPING	202,304	203,126	405,430	0	405,430	9.00
10.00	01000	DIETARY	166,077	109,623	275,700	16,630	292,330	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	202,508	1,556	204,064	0	204,064	13.00
15.00	01500	PHARMACY	0	2,019,607	2,019,607	0	2,019,607	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	266,076	28,863	294,939	0	294,939	16.00
17.00	01700	SOCIAL SERVICE	22,052	18,135	40,187	0	40,187	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	625,000	625,000	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,335,867	128,634	1,464,501	20,704	1,485,205	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	535,434	862,671	1,398,105	-55,461	1,342,644	50.00
53.00	05300	ANESTHESIOLOGY	0	675,784	675,784	-632,775	43,009	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	452,786	207,218	660,004	-98,298	561,706	54.00
54.01	05401	ULTRASOUND	143,498	82,763	226,261	260	226,521	54.01
56.00	05600	RADIOISOTOPE	0	285,848	285,848	3,529	289,377	56.00
57.00	05700	CT SCAN	0	112,809	112,809	71,492	184,301	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	116,777	116,777	26,806	143,583	58.00
60.00	06000	LABORATORY	604,170	1,070,013	1,674,183	-16,748	1,657,435	60.00
65.00	06500	RESPIRATORY THERAPY	52,797	25,009	77,806	-1,906	75,900	65.00
66.00	06600	PHYSICAL THERAPY	701,633	71,144	772,777	-2,375	770,402	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,153	2,774	37,927	12,959	50,886	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	105,867	105,867	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	263,392	263,392	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	135,746	135,746	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	111,141	111,141	0	111,141	75.01
75.02	03952	WOUND CENTER	0	114,784	114,784	0	114,784	75.02
76.00	03953	CARDIAC REHAB	118,600	2,406	121,006	-7,419	113,587	76.00
76.01	03030	DIABETES EDUCATION	79,665	6,228	85,893	-16,940	68,953	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,000,326	1,763,553	6,763,879	-224,389	6,539,490	88.00
91.00	09100	EMERGENCY	801,487	1,289,256	2,090,743	-21,932	2,068,811	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	786,817	191,525	978,342	-39,943	938,399	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		28,192	28,192	-28,192	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,117,999	20,244,192	35,362,191	228,060	35,590,251	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	124,829	451,618	576,447	-222,797	353,650	194.00
194.01	07951	THE CENTER - FITNESS CENTER	62,322	9,957	72,279	-5,263	67,016	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	15,305,150	20,705,767	36,010,917	0	36,010,917	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1349

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

Worksheet A

Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-22,797	493,051	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	176,067	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-31,158	931,590	2.00
3.00	00300	OTHER CAP RELATED COST	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,407,426	4,347,411	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-407,454	5,666,755	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	243,877	6.00
7.00	00700	OPERATION OF PLANT	0	648,061	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	41,908	8.00
9.00	00900	HOUSEKEEPING	0	405,430	9.00
10.00	01000	DIETARY	0	292,330	10.00
11.00	01100	CAFETERIA	-31,563	-31,563	11.00
13.00	01300	NURSING ADMINISTRATION	0	204,064	13.00
15.00	01500	PHARMACY	-888,631	1,130,976	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-764	294,175	16.00
17.00	01700	SOCIAL SERVICE	0	40,187	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-625,000	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-12,600	1,472,605	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-409,045	933,599	50.00
53.00	05300	ANESTHESIOLOGY	0	43,009	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-940	560,766	54.00
54.01	05401	ULTRASOUND	0	226,521	54.01
56.00	05600	RADIOISOTOPE	0	289,377	56.00
57.00	05700	CT SCAN	0	184,301	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	143,583	58.00
60.00	06000	LABORATORY	0	1,657,435	60.00
65.00	06500	RESPIRATORY THERAPY	0	75,900	65.00
66.00	06600	PHYSICAL THERAPY	0	770,402	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	50,886	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,467	109,334	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	263,392	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	135,746	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03951	SLEEP LAB	0	111,141	75.01
75.02	03952	WOUND CENTER	0	114,784	75.02
76.00	03953	CARDIAC REHAB	0	113,587	76.00
76.01	03030	DIABETES EDUCATION	0	68,953	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-8,847	6,530,643	88.00
91.00	09100	EMERGENCY	-385,288	1,683,523	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	938,399	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,228,046	31,362,205	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	353,650	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	67,016	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,228,046	31,782,871	200.00

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
11/25/2020 8:47 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS COST OF SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	97,487		1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	407,518		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	505,005		
	B - TO RECLASS INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,395		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,797		2.00
	0		0	28,192		
	C - TO RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	16,748	0		1.00
	0		16,748	0		
	D - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP RELATED COST	3.00	0	73,783		1.00
	0		0	73,783		
	E - TO RECLASS TELEPHONE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,053		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		0.00	0	0		5.00
	0		0	20,053		
	F - SURGERY-FREESTANDING CLINICS					
1.00	OPERATING ROOM	50.00	0	216,020		1.00
	0		0	216,020		
	G - TO RECLASS CRNA EXPENSES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	625,000		1.00
	0		0	625,000		
	H - TO RECLASS NORTHCAMPUS BLDG					
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	169,505		1.00
	0		0	169,505		
	I - TO RECLASS CT SCAN					
1.00	CT SCAN	57.00	71,492	0		1.00
	0		71,492	0		
	J - TO RECLASS RECRUITMENT EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	0	13,982		1.00
	0		0	13,982		
	K - TO RECLASS STRESS TEST SALARIES					
1.00	RADIOISOTOPE	56.00	3,529	0		1.00
2.00	ULTRASOUND	54.01	260	0		2.00
	0		3,789	0		
	L - TO RECLASS MRI SALARIES					
1.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	26,806	0		1.00
	0		26,806	0		
	M - TO RECLASS DIETARY SALARIES					
1.00	DIETARY	10.00	16,630	0		1.00
	0		16,630	0		
	O - UTILITY EXPENSE					
1.00	OPERATION OF PLANT	7.00	0	6,916		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		0.00	0	0		5.00
	0		0	6,916		
	P - HOME HEALTH BILLER					
1.00	ADMINISTRATIVE & GENERAL	5.00	30,911	0		1.00
	0		30,911	0		
	Q - RHC - HOSPITAL SUPPORT					
1.00	ADULTS & PEDIATRICS	30.00	35,000	0		1.00
2.00	OPERATING ROOM	50.00	0	193,026		2.00
	0		35,000	193,026		
	R - PATIENT SCREENERS					
1.00	ADMINISTRATIVE & GENERAL	5.00	19,963	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		0.00	0	0		5.00
6.00		0.00	0	0		6.00

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
11/25/2020 8:47 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		19,963	0	
S - MISCODED AS IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	8,380	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	135,746	2.00
	TOTALS		0	144,126	
500.00	Grand Total: Increases		221,339	1,995,608	500.00

RECLASSIFICATIONS

Provider CCN: 14-1349

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

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS COST OF SUPPLIES						
1.00	OPERATING ROOM	50.00	0	461,283	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	13,457	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	7,775	0		3.00
4.00	EMERGENCY	91.00	0	21,932	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	558	0		5.00
	0		0	505,005			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	28,192	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	28,192			
	C - TO RECLASS EKG SALARIES						
1.00	LABORATORY	60.00	16,748	0	0		1.00
	0		16,748	0			
	D - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,783	12		1.00
	0		0	73,783			
	E - TO RECLASS TELEPHONE EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	611	0		1.00
2.00	PHYSICAL THERAPY	66.00	0	1,172	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	10,288	0		3.00
4.00	HOME HEALTH AGENCY	101.00	0	5,962	0		4.00
5.00	FREESTANDING CLINICS	194.00	0	2,020	0		5.00
	0		0	20,053			
	F - SURGERY-FREESTANDING CLINICS						
1.00	FREESTANDING CLINICS	194.00	0	216,020	0		1.00
	0		0	216,020			
	G - TO RECLASS CRNA EXPENSES						
1.00	ANESTHESIOLOGY	53.00	0	625,000	0		1.00
	0		0	625,000			
	H - TO RECLASS NORTHCAMPUS BLDG						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	169,505	9		1.00
	0		0	169,505			
	I - TO RECLASS CT SCAN						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	71,492	0	0		1.00
	0		71,492	0			
	J - TO RECLASS RECRUITMENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,982	0		1.00
	0		0	13,982			
	K - TO RECLASS STRESS TEST SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	3,789	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		3,789	0			
	L - TO RECLASS MRI SALARIES						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	26,806	0	0		1.00
	0		26,806	0			
	M - TO RECLASS DIETARY SALARIES						
1.00	DIABETES EDUCATION	76.01	16,630	0	0		1.00
	0		16,630	0			
	O - UTILITY EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	79	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	57	0		2.00
3.00	HOME HEALTH AGENCY	101.00	0	823	0		3.00
4.00	FREESTANDING CLINICS	194.00	0	4,494	0		4.00
5.00	THE CENTER - FITNESS CENTER	194.01	0	1,463	0		5.00
	0		0	6,916			
	P - HOME HEALTH BILLER						
1.00	HOME HEALTH AGENCY	101.00	30,911	0	0		1.00
	0		30,911	0			
	Q - RHC - HOSPITAL SUPPORT						
1.00	RURAL HEALTH CLINIC	88.00	35,000	193,026	0		1.00
2.00		0.00	0	0	0		2.00
	0		35,000	193,026			
	R - PATIENT SCREENERS						
1.00	HOME HEALTH AGENCY	101.00	2,247	0	0		1.00
2.00	FREESTANDING CLINICS	194.00	263	0	0		2.00
3.00	THE CENTER - FITNESS CENTER	194.01	3,800	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	228	0	0		4.00
5.00	OPERATING ROOM	50.00	3,224	0	0		5.00
6.00	RESPIRATORY THERAPY	65.00	1,348	0	0		6.00
7.00	PHYSICAL THERAPY	66.00	1,124	0	0		7.00
8.00	CARDIAC REHAB	76.00	7,419	0	0		8.00
9.00	DIABETES EDUCATION	76.01	310	0	0		9.00
	TOTALS		19,963	0			

RECLASSIFICATIONS

Provider CCN: 14-1349

Period:
From 07/01/2019
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Worksheet A-6

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	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	S - MISCODED AS IMPLANTS						
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	144,126	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	144,126			
500.00	Grand Total: Decreases		221,339	1,995,608			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
11/25/2020 8:47 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	356,334	0	0	0	0	1.00	
2.00	Land Improvements	838,536	0	0	0	45,066	2.00	
3.00	Buildings and Fixtures	17,065,817	0	0	0	26,742	3.00	
4.00	Building Improvements	144,050	1,467,461	0	1,467,461	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	12,616,935	0	0	0	140,925	6.00	
7.00	HIT designated Assets	891,921	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	31,913,593	1,467,461	0	1,467,461	212,733	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	31,913,593	1,467,461	0	1,467,461	212,733	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	356,334	0					1.00
2.00	Land Improvements	793,470	0					
3.00	Buildings and Fixtures	17,039,075	0					
4.00	Building Improvements	1,611,511	0					
5.00	Fixed Equipment	0	0					
6.00	Movable Equipment	12,476,010	0					
7.00	HIT designated Assets	891,921	0					
8.00	Subtotal (sum of lines 1-7)	33,168,321	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	33,168,321	0					

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	625,395	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	932,688	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,558,083	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	625,395				1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	932,688				2.00
3.00	Total (sum of lines 1-2)	0	1,558,083				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	16,526,036	0	16,526,036	0.503659	37,161	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	2,918,019	0	2,918,019	0.088931	6,562	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	13,367,931	0	13,367,931	0.407410	30,060	2.00
3.00	Total (sum of lines 1-2)	32,811,986	0	32,811,986	1.000000	73,783	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	37,161	455,890	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	6,562	169,505	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	30,060	901,530	0	2.00
3.00	Total (sum of lines 1-2)	0	0	73,783	1,526,925	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	37,161	0	0	493,051	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	6,562	0	0	176,067	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	30,060	0	0	931,590	2.00
3.00	Total (sum of lines 1-2)	0	73,783	0	0	1,600,708	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1349

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

Worksheet A-8

Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-22,797	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-5,395	ADMINISTRATIVE & GENERAL	5.00	11	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	-21,496	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-795,273			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-150	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,563	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	3,467	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-764	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-625,000	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1349

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

Worksheet A-8

Date/Time Prepared:
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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
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	-766		CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BILL COPY CHARGES	B	-1,597		ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-56,353		ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	TRANSMED SERVICE REVENUE	B	-1,757		ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PERSONAL USE OF AUTO	A	-7,434		ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MARKETING SALARY	A	-41,340		ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MARKETING EXPENSES	A	-86,648		ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MARKETING EMPLOYEE BENEFITS	A	-15,544		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	LOBBYING EXPENSES	A	-9,018		ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	SELF INSURANCE EXPENSE	A	-1,129,374		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	MALPRACTICE INSURANCE DIVIDEND	B	-150,615		ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	WORKER'S COMPENSATION INSURANCE DIVI	B	-91,051		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	RHC SELF INSURANCE EXPENSE	A	-166,668		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	USAC SUBSIDY	B	-12,811		ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	EMPLOYEE ACTIVITIES	B	-102		ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	340B CONTRACT EXPENSES	A	-888,631		PHARMACY	15.00	0	33.14
33.15	HOSPICE REVENUE	A	-12,600		ADULTS & PEDIATRICS	30.00	0	33.15
33.16	PHYSICIAN ASSISTANT	B	-8,847		RURAL HEALTH CLINIC	88.00	0	33.16
33.17	MRI OFFSET	A	-30,392		CAP REL COSTS-MVBLE EQUIP	2.00	9	33.17
33.18	DIRECTOR OF RELATIONS NONALLOWABLE P	A	-12,738		ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	DIRECTOR OF RELATIONS NONALLOWABLE B	A	-4,789		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,228,046					50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1349

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

Worksheet A-8-2

Date/Time Prepared:
11/25/2020 8:47 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	35,000	0	35,000	0	0	1.00
2.00	91.00	EMERGENCY	1,147,148	385,288	761,860	0	0	2.00
3.00	50.00	OPERATING ROOM	216,020	216,020	0	0	0	3.00
4.00	75.01	SLEEP LAB	10,000	0	10,000	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	14,000	0	14,000	0	0	5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	940	940	0	0	0	6.00
7.00	60.00	LABORATORY	18,800	0	18,800	0	0	7.00
8.00	50.00	OPERATING ROOM	193,025	193,025	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			1,634,933	795,273	839,660		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	75.01	SLEEP LAB	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	385,288		2.00
3.00	50.00	OPERATING ROOM	0	0	0	216,020		3.00
4.00	75.01	SLEEP LAB	0	0	0	0		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0		5.00
6.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	940		6.00
7.00	60.00	LABORATORY	0	0	0	0		7.00
8.00	50.00	OPERATING ROOM	0	0	0	193,025		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	795,273		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2020 8:47 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					12	1.00
2.00	Line 1 multiplied by 15 hours per week					180	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.40	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	218.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.36	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.68	38.68	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					16,903	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					16,903	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					16,903	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					16,903	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1349		Period: From 07/01/2019 To 06/30/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2020 8:47 am		
				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.36	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						16,903	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						16,903	63.00
64.00	Total cost of outside supplier services (from your records)						13,110	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						0	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP	
			0	1.00	1.01	2.00	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	493,051	493,051			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	176,067	0	176,067		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	931,590			931,590	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,347,411	0	0	0	4,347,411
5.00	00500	ADMINISTRATIVE & GENERAL	5,666,755	46,733	35,654	281,171	959,907
6.00	00600	MAINTENANCE & REPAIRS	243,877	23,374	0	1,142	68,445
7.00	00700	OPERATION OF PLANT	648,061	40,475	4,868	41,897	0
8.00	00800	LAUNDRY & LINEN SERVICE	41,908	3,677	0	0	0
9.00	00900	HOUSEKEEPING	405,430	4,996	0	3,495	57,668
10.00	01000	DIETARY	292,330	11,498	0	6,285	52,082
11.00	01100	CAFETERIA	-31,563	6,391	0	0	0
13.00	01300	NURSING ADMINISTRATION	204,064	2,142	0	82	57,726
15.00	01500	PHARMACY	1,130,976	3,223	0	226	0
16.00	01600	MEDICAL RECORDS & LIBRARY	294,175	10,466	8,867	5,002	75,847
17.00	01700	SOCIAL SERVICE	40,187	0	0	0	6,286
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,472,605	46,419	0	45,388	390,709
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	933,599	43,335	0	119,747	151,710
53.00	05300	ANESTHESIOLOGY	43,009	614	0	1,354	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	560,766	8,659	0	72,954	101,049
54.01	05401	ULTRASOUND	226,521	2,505	0	58,306	40,979
56.00	05600	RADIOISOTOPE	289,377	2,009	0	0	1,006
57.00	05700	CT SCAN	184,301	2,526	0	312	20,379
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	143,583	6,475	0	131,800	7,641
60.00	06000	LABORATORY	1,657,435	12,552	0	32,748	167,448
65.00	06500	RESPIRATORY THERAPY	75,900	1,277	0	816	14,666
66.00	06600	PHYSICAL THERAPY	770,402	3,356	42,003	21,986	199,684
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	50,886	1,214	0	2,379	13,715
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,334	3,984	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	263,392	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	135,746	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03951	SLEEP LAB	111,141	3,963	0	237	0
75.02	03952	WOUND CENTER	114,784	10,361	0	0	0
76.00	03953	CARDIAC REHAB	113,587	6,273	0	8,563	31,693
76.01	03030	DIABETES EDUCATION	68,953	1,319	0	0	17,880
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,530,643	98,239	53,136	31,280	1,415,397
91.00	09100	EMERGENCY	1,683,523	20,806	0	39,928	228,469
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	938,399	11,450	0	3,981	214,835
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,362,205	440,311	144,528	911,079	4,295,221
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,395	0	0	0
194.00	07950	FREESTANDING CLINICS	353,650	51,345	0	9,088	35,508
194.01	07951	THE CENTER - FITNESS CENTER	67,016	0	31,539	11,423	16,682
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	31,782,871	493,051	176,067	931,590	4,347,411

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4A	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,990,220	6,990,220				5.00
6.00	00600	MAINTENANCE & REPAIRS	336,838	94,874	431,712			6.00
7.00	00700	OPERATION OF PLANT	735,301	207,106	32,838	975,245		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,585	12,840	2,983	8,318	69,726	8.00
9.00	00900	HOUSEKEEPING	471,589	132,828	4,053	11,301	0	9.00
10.00	01000	DIETARY	362,195	102,016	9,329	26,012	14	10.00
11.00	01100	CAFETERIA	-25,172	0	5,185	14,458	0	11.00
13.00	01300	NURSING ADMINISTRATION	264,014	74,362	1,738	4,846	0	13.00
15.00	01500	PHARMACY	1,134,425	319,523	2,615	7,292	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	394,357	111,075	16,286	45,411	0	16.00
17.00	01700	SOCIAL SERVICE	46,473	13,090	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,955,121	550,681	37,662	105,011	18,805	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,248,391	351,623	35,159	98,034	12,634	50.00
53.00	05300	ANESTHESIOLOGY	44,977	12,668	498	1,389	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	743,428	209,395	7,025	19,588	9,388	54.00
54.01	05401	ULTRASOUND	328,311	92,472	2,032	5,666	2,320	54.01
56.00	05600	RADIOISOTOPE	292,392	82,355	1,630	4,546	36	56.00
57.00	05700	CT SCAN	207,518	58,450	2,049	5,714	335	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	289,499	81,541	5,253	14,648	1,360	58.00
60.00	06000	LABORATORY	1,870,183	526,758	10,184	28,395	0	60.00
65.00	06500	RESPIRATORY THERAPY	92,659	26,098	1,036	2,888	0	65.00
66.00	06600	PHYSICAL THERAPY	1,037,431	292,204	39,648	110,551	4,022	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	68,194	19,208	985	2,746	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,318	31,917	3,232	9,013	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	263,392	74,187	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,746	38,234	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	115,341	32,487	3,215	8,965	0	75.01
75.02	03952	WOUND CENTER	125,145	35,248	8,406	23,439	0	75.02
76.00	03953	CARDIAC REHAB	160,116	45,098	5,089	14,190	0	76.00
76.01	03030	DIABETES EDUCATION	88,152	24,829	1,070	2,983	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,128,695	2,289,546	95,825	130,250	0	88.00
91.00	09100	EMERGENCY	1,972,726	555,640	16,881	47,068	16,321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,168,665	329,167	9,289	25,902	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,205,225	6,827,520	361,195	778,624	65,235	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,395	393	1,132	3,157	0	190.00
194.00	07950	FREESTANDING CLINICS	449,591	126,632	41,658	116,154	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	126,660	35,675	27,727	77,310	4,491	194.01
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)	31,782,871	6,990,220	431,712	975,245	69,726	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1349

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	619,771					9.00
10.00	01000	DIETARY	2,439	502,005				10.00
11.00	01100	CAFETERIA	11,068	327,922	333,461			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	40,708	385,668		13.00
15.00	01500	PHARMACY	3,830	0	32,913	0	1,500,598	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,877	0	31,181	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,299	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	86,149	174,083	43,523	173,968	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	81,882	0	63,661	75,895	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	12,178	0	9,744	0	0	54.00
54.01	05401	ULTRASOUND	10,474	0	3,248	0	0	54.01
56.00	05600	RADIOISOTOPE	1,798	0	1,299	0	0	56.00
57.00	05700	CT SCAN	9,708	0	3,681	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	866	0	0	58.00
60.00	06000	LABORATORY	14,663	0	37,460	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,329	0	9,744	7,317	0	65.00
66.00	06600	PHYSICAL THERAPY	23,267	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,500,598	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	3,048	0	0	0	0	75.01
75.02	03952	WOUND CENTER	9,067	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	6,159	0	2,815	13,477	0	76.00
76.01	03030	DIABETES EDUCATION	1,110	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	204,184	0	7,146	0	0	88.00
91.00	09100	EMERGENCY	67,125	0	40,275	115,011	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	2,189	0	217	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	556,544	502,005	329,780	385,668	1,500,598	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	29,389	0	3,681	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	33,838	0	0	0	0	194.01
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)	619,771	502,005	333,461	385,668	1,500,598	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	603,187					16.00
17.00	01700	SOCIAL SERVICE	0	60,862				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,016	60,862	0	3,275,881	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	58,182	0	0	2,025,461	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	59,532	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	10,519	0	0	1,021,265	0	54.00
54.01	05401	ULTRASOUND	3,287	0	0	447,810	0	54.01
56.00	05600	RADIOISOTOPE	8,547	0	0	392,603	0	56.00
57.00	05700	CT SCAN	657	0	0	288,112	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	986	0	0	394,153	0	58.00
60.00	06000	LABORATORY	32,543	0	0	2,520,186	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,259	0	0	146,330	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,507,123	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	91,133	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	157,480	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	337,579	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,674,578	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	6,903	0	0	169,959	0	75.01
75.02	03952	WOUND CENTER	2,958	0	0	204,263	0	75.02
76.00	03953	CARDIAC REHAB	657	0	0	247,601	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	118,144	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	292,555	0	0	11,148,201	0	88.00
91.00	09100	EMERGENCY	94,340	0	0	2,925,387	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,535,429	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	587,409	60,862	0	30,688,210	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	6,077	0	190.00
194.00	07950	FREESTANDING CLINICS	15,778	0	0	782,883	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	305,701	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	603,187	60,862	0	31,782,871	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03951	SLEEP LAB	75.01
75.02	03952	WOUND CENTER	75.02
76.00	03953	CARDIAC REHAB	76.00
76.01	03030	DIABETES EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	FREESTANDING CLINICS	194.00
194.01	07951	THE CENTER - FITNESS CENTER	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,646	46,733	35,654	281,171	402,204 5.00
6.00	00600	MAINTENANCE & REPAIRS	490	23,374	0	1,142	25,006 6.00
7.00	00700	OPERATION OF PLANT	0	40,475	4,868	41,897	87,240 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,677	0	0	3,677 8.00
9.00	00900	HOUSEKEEPING	65	4,996	0	3,495	8,556 9.00
10.00	01000	DIETARY	0	11,498	0	6,285	17,783 10.00
11.00	01100	CAFETERIA	0	6,391	0	0	6,391 11.00
13.00	01300	NURSING ADMINISTRATION	0	2,142	0	82	2,224 13.00
15.00	01500	PHARMACY	5,232	3,223	0	226	8,681 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,466	8,867	5,002	24,335 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,371	46,419	0	45,388	109,178 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,388	43,335	0	119,747	192,470 50.00
53.00	05300	ANESTHESIOLOGY	0	614	0	1,354	1,968 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	8,659	0	72,954	81,613 54.00
54.01	05401	ULTRASOUND	0	2,505	0	58,306	60,811 54.01
56.00	05600	RADIOISOTOPE	0	2,009	0	0	2,009 56.00
57.00	05700	CT SCAN	0	2,526	0	312	2,838 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,475	0	131,800	138,275 58.00
60.00	06000	LABORATORY	17,436	12,552	0	32,748	62,736 60.00
65.00	06500	RESPIRATORY THERAPY	11,546	1,277	0	816	13,639 65.00
66.00	06600	PHYSICAL THERAPY	0	3,356	42,003	21,986	67,345 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	29	1,214	0	2,379	3,622 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,984	0	0	3,984 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01	03951	SLEEP LAB	0	3,963	0	237	4,200 75.01
75.02	03952	WOUND CENTER	0	10,361	0	0	10,361 75.02
76.00	03953	CARDIAC REHAB	0	6,273	0	8,563	14,836 76.00
76.01	03030	DIABETES EDUCATION	0	1,319	0	0	1,319 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,791	98,239	53,136	31,280	197,446 88.00
91.00	09100	EMERGENCY	8,753	20,806	0	39,928	69,487 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	11,450	0	3,981	15,431 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	143,747	440,311	144,528	911,079	1,639,665 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,395	0	0	1,395 190.00
194.00	07950	FREESTANDING CLINICS	0	51,345	0	9,088	60,433 194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	31,539	11,423	42,962 194.01
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)	143,747	493,051	176,067	931,590	1,744,455 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	402,204				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	5,459	30,465			6.00
7.00	00700	OPERATION OF PLANT	0	11,916	2,317	101,473		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	739	211	865	5,492	8.00
9.00	00900	HOUSEKEEPING	0	7,643	286	1,176	0	9.00
10.00	01000	DIETARY	0	5,870	658	2,707	1	10.00
11.00	01100	CAFETERIA	0	0	366	1,504	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,279	123	504	0	13.00
15.00	01500	PHARMACY	0	18,384	185	759	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,391	1,149	4,725	0	16.00
17.00	01700	SOCIAL SERVICE	0	753	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	31,685	2,658	10,926	1,481	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,231	2,481	10,200	995	50.00
53.00	05300	ANESTHESIOLOGY	0	729	35	145	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	12,048	496	2,038	739	54.00
54.01	05401	ULTRASOUND	0	5,321	143	590	183	54.01
56.00	05600	RADIOISOTOPE	0	4,739	115	473	3	56.00
57.00	05700	CT SCAN	0	3,363	145	595	26	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,692	371	1,524	107	58.00
60.00	06000	LABORATORY	0	30,308	719	2,955	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,502	73	301	0	65.00
66.00	06600	PHYSICAL THERAPY	0	16,813	2,798	11,503	317	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,105	70	286	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,836	228	938	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	4,269	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,200	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	1,869	227	933	0	75.01
75.02	03952	WOUND CENTER	0	2,028	593	2,439	0	75.02
76.00	03953	CARDIAC REHAB	0	2,595	359	1,476	0	76.00
76.01	03030	DIABETES EDUCATION	0	1,429	76	310	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	131,737	6,759	13,551	0	88.00
91.00	09100	EMERGENCY	0	31,970	1,191	4,897	1,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	18,939	656	2,695	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	392,842	25,488	81,015	5,138	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	23	80	328	0	190.00
194.00	07950	FREESTANDING CLINICS	0	7,286	2,940	12,086	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	2,053	1,957	8,044	354	194.01
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	402,204	30,465	101,473	5,492	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1349

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	17,661					9.00
10.00	01000	DIETARY	69	27,088				10.00
11.00	01100	CAFETERIA	315	17,695	24,000			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,930	10,060		13.00
15.00	01500	PHARMACY	109	0	2,369	0	30,487	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139	0	2,244	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	94	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,455	9,393	3,132	4,537	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,333	0	4,581	1,980	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	347	0	701	0	0	54.00
54.01	05401	ULTRASOUND	298	0	234	0	0	54.01
56.00	05600	RADIOISOTOPE	51	0	94	0	0	56.00
57.00	05700	CT SCAN	277	0	265	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	62	0	0	58.00
60.00	06000	LABORATORY	418	0	2,696	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	38	0	701	191	0	65.00
66.00	06600	PHYSICAL THERAPY	663	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	30,487	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	87	0	0	0	0	75.01
75.02	03952	WOUND CENTER	258	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	176	0	203	352	0	76.00
76.01	03030	DIABETES EDUCATION	32	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,820	0	514	0	0	88.00
91.00	09100	EMERGENCY	1,913	0	2,899	3,000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	62	0	16	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,860	27,088	23,735	10,060	30,487	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	837	0	265	0	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	964	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	2,271	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,661	27,088	26,271	10,060	30,487	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,983					16.00
17.00	01700	SOCIAL SERVICE	0	847				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,525	847		180,817	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,760	0		239,031	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		2,877	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	680	0		98,662	0	54.00
54.01	05401	ULTRASOUND	212	0		67,792	0	54.01
56.00	05600	RADIOISOTOPE	552	0		8,036	0	56.00
57.00	05700	CT SCAN	42	0		7,551	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	64	0		145,095	0	58.00
60.00	06000	LABORATORY	2,103	0		101,935	0	60.00
65.00	06500	RESPIRATORY THERAPY	340	0		16,785	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0		99,439	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		5,083	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		6,986	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		4,269	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		32,687	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		0	0	75.00
75.01	03951	SLEEP LAB	446	0		7,762	0	75.01
75.02	03952	WOUND CENTER	191	0		15,870	0	75.02
76.00	03953	CARDIAC REHAB	42	0		20,039	0	76.00
76.01	03030	DIABETES EDUCATION	0	0		3,166	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	18,909	0		374,736	0	88.00
91.00	09100	EMERGENCY	6,097	0		122,740	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0		37,799	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,963	847	0	1,599,157	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		1,826	0	190.00
194.00	07950	FREESTANDING CLINICS	1,020	0		84,867	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0		56,334	0	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	2,271	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,983	847	0	1,744,455	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
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
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
75.01	03951	SLEEP LAB	75.01
75.02	03952	WOUND CENTER	75.02
76.00	03953	CARDIAC REHAB	76.00
76.01	03030	DIABETES EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
194.00	07950	FREESTANDING CLINICS	194.00
194.01	07951	THE CENTER - FITNESS CENTER	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

Period:
From 07/01/2019
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Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00	4.00	5A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	70,666				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	27,343			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			931,923		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	15,251,072		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,698	5,537	281,274	3,367,433	-6,990,220
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	1,142	240,112	0
7.00	00700	OPERATION OF PLANT	5,801	756	41,912	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0
9.00	00900	HOUSEKEEPING	716	0	3,496	202,304	0
10.00	01000	DIETARY	1,648	0	6,287	182,707	0
11.00	01100	CAFETERIA	916	0	0	0	25,172
13.00	01300	NURSING ADMINISTRATION	307	0	82	202,508	0
15.00	01500	PHARMACY	462	0	226	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,377	5,004	266,076	0
17.00	01700	SOCIAL SERVICE	0	0	0	22,052	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,653	0	45,404	1,370,639	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,211	0	119,790	532,210	0
53.00	05300	ANESTHESIOLOGY	88	0	1,354	0	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,241	0	72,980	354,488	0
54.01	05401	ULTRASOUND	359	0	58,327	143,758	0
56.00	05600	RADIOISOTOPE	288	0	0	3,529	0
57.00	05700	CT SCAN	362	0	312	71,492	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928	0	131,847	26,806	0
60.00	06000	LABORATORY	1,799	0	32,760	587,422	0
65.00	06500	RESPIRATORY THERAPY	183	0	816	51,449	0
66.00	06600	PHYSICAL THERAPY	481	6,523	21,994	700,509	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	174	0	2,380	48,112	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03951	SLEEP LAB	568	0	237	0	0
75.02	03952	WOUND CENTER	1,485	0	0	0	0
76.00	03953	CARDIAC REHAB	899	0	8,566	111,181	0
76.01	03030	DIABETES EDUCATION	189	0	0	62,725	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	31,291	4,965,326	0
91.00	09100	EMERGENCY	2,982	0	39,942	801,487	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,641	0	3,982	753,659	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,107	22,445	911,405	15,067,984	-6,965,048
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	0
194.00	07950	FREESTANDING CLINICS	7,359	0	9,091	124,566	0
194.01	07951	THE CENTER - FITNESS CENTER	0	4,898	11,427	58,522	0
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)	493,051	176,067	931,590	4,347,411	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.977203	6.439198	0.999643	0.285056	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1349

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

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Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,817,823				5.00
6.00	00600	MAINTENANCE & REPAIRS	336,838	76,263			6.00
7.00	00700	OPERATION OF PLANT	735,301	5,801	61,787		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,585	527	527	9,796	8.00
9.00	00900	HOUSEKEEPING	471,589	716	716	0	198,235 9.00
10.00	01000	DIETARY	362,195	1,648	1,648	2	780 10.00
11.00	01100	CAFETERIA	0	916	916	0	3,540 11.00
13.00	01300	NURSING ADMINISTRATION	264,014	307	307	0	0 13.00
15.00	01500	PHARMACY	1,134,425	462	462	0	1,225 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	394,357	2,877	2,877	0	1,560 16.00
17.00	01700	SOCIAL SERVICE	46,473	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,955,121	6,653	6,653	2,642	27,555 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,248,391	6,211	6,211	1,775	26,190 50.00
53.00	05300	ANESTHESIOLOGY	44,977	88	88	0	0 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	743,428	1,241	1,241	1,319	3,895 54.00
54.01	05401	ULTRASOUND	328,311	359	359	326	3,350 54.01
56.00	05600	RADIOISOTOPE	292,392	288	288	5	575 56.00
57.00	05700	CT SCAN	207,518	362	362	47	3,105 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	289,499	928	928	191	0 58.00
60.00	06000	LABORATORY	1,870,183	1,799	1,799	0	4,690 60.00
65.00	06500	RESPIRATORY THERAPY	92,659	183	183	0	425 65.00
66.00	06600	PHYSICAL THERAPY	1,037,431	7,004	7,004	565	7,442 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	68,194	174	174	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,318	571	571	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	263,392	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	135,746	0	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
75.01	03951	SLEEP LAB	115,341	568	568	0	975 75.01
75.02	03952	WOUND CENTER	125,145	1,485	1,485	0	2,900 75.02
76.00	03953	CARDIAC REHAB	160,116	899	899	0	1,970 76.00
76.01	03030	DIABETES EDUCATION	88,152	189	189	0	355 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,128,695	16,927	8,252	0	65,310 88.00
91.00	09100	EMERGENCY	1,972,726	2,982	2,982	2,293	21,470 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,168,665	1,641	1,641	0	700 101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,240,177	63,806	49,330	9,165	178,012 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,395	200	200	0	0 190.00
194.00	07950	FREESTANDING CLINICS	449,591	7,359	7,359	0	9,400 194.00
194.01	07951	THE CENTER - FITNESS CENTER	126,660	4,898	4,898	631	10,823 194.01
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)	6,990,220	431,712	975,245	69,726	619,771 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.281661	5.660832	15.783984	7.117803	3.126446 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	402,204	30,465	101,473	5,492	17,661 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.016206	0.399473	1.642303	0.560637	0.089091 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: 14-1349

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	23,854					10.00
11.00	01100	CAFETERIA	15,582	1,540				11.00
13.00	01300	NURSING ADMINISTRATION	0	188	98,044			13.00
15.00	01500	PHARMACY	0	152	0	2,019,607		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	144	0	0	1,835	16.00
17.00	01700	SOCIAL SERVICE	0	6	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,272	201	44,226	0	213	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	294	19,294	0	177	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	45	0	0	32	54.00
54.01	05401	ULTRASOUND	0	15	0	0	10	54.01
56.00	05600	RADIOISOTOPE	0	6	0	0	26	56.00
57.00	05700	CT SCAN	0	17	0	0	2	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4	0	0	3	58.00
60.00	06000	LABORATORY	0	173	0	0	99	60.00
65.00	06500	RESPIRATORY THERAPY	0	45	1,860	0	16	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,019,607	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	21	75.01
75.02	03952	WOUND CENTER	0	0	0	0	9	75.02
76.00	03953	CARDIAC REHAB	0	13	3,426	0	2	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	33	0	0	890	88.00
91.00	09100	EMERGENCY	0	186	29,238	0	287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,854	1,523	98,044	2,019,607	1,787	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	17	0	0	48	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	0	0	0	0	194.01
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)	502,005	333,461	385,668	1,500,598	603,187	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.044898	216.533117	3.933622	0.743015	328.712262	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,088	26,271	10,060	30,487	38,983	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.135575	15.584416	0.102607	0.015096	21.244142	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: 14-1349

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

Worksheet B-1

Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	916	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	916	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
54.01	05401	ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
75.01	03951	SLEEP LAB	0	75.01
75.02	03952	WOUND CENTER	0	75.02
76.00	03953	CARDIAC REHAB	0	76.00
76.01	03030	DIABETES EDUCATION	0	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	916	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
194.00	07950	FREESTANDING CLINICS	0	194.00
194.01	07951	THE CENTER - FITNESS CENTER	0	194.01
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)	60,862	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	66.443231	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	847	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.924672	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 8:47 am

		Title XVIII		Hospital		Cost
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	Total Costs
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3,275,881		3,275,881	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,025,461		2,025,461	0	0 50.00
53.00	05300 ANESTHESIOLOGY	59,532		59,532	0	0 53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	1,021,265		1,021,265	0	0 54.00
54.01	05401 ULTRASOUND	447,810		447,810	0	0 54.01
56.00	05600 RADIOISOTOPE	392,603		392,603	0	0 56.00
57.00	05700 CT SCAN	288,112		288,112	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	394,153		394,153	0	0 58.00
60.00	06000 LABORATORY	2,520,186		2,520,186	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	146,330	0	146,330	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,507,123	0	1,507,123	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	91,133		91,133	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157,480		157,480	0	0 71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	337,579		337,579	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,674,578		1,674,578	0	0 73.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0 75.00
75.01	03951 SLEEP LAB	169,959		169,959	0	0 75.01
75.02	03952 WOUND CENTER	204,263		204,263	0	0 75.02
76.00	03953 CARDIAC REHAB	247,601		247,601	0	0 76.00
76.01	03030 DIABETES EDUCATION	118,144		118,144	0	0 76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	11,148,201		11,148,201	0	0 88.00
91.00	09100 EMERGENCY	2,925,387		2,925,387	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	739,643		739,643	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,535,429		1,535,429		0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	31,427,853	0	31,427,853	0	0 200.00
201.00	Less Observation Beds	739,643		739,643		0 201.00
202.00	Total (see instructions)	30,688,210	0	30,688,210	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 8:47 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,730,178		1,730,178		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	277,100	4,861,859	5,138,959	0.394138	50.00
53.00	05300	ANESTHESIOLOGY	19,802	136,038	155,840	0.382007	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	104,458	3,227,492	3,331,950	0.306507	54.00
54.01	05401	ULTRASOUND	161,101	4,126,549	4,287,650	0.104442	54.01
56.00	05600	RADIOISOTOPE	20,310	1,465,993	1,486,303	0.264147	56.00
57.00	05700	CT SCAN	173,540	13,058,393	13,231,933	0.021774	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,541	2,905,475	2,924,016	0.134799	58.00
60.00	06000	LABORATORY	704,537	13,679,643	14,384,180	0.175205	60.00
65.00	06500	RESPIRATORY THERAPY	36,004	379,779	415,783	0.351938	65.00
66.00	06600	PHYSICAL THERAPY	656,695	5,017,572	5,674,267	0.265607	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	18,900	614,855	633,755	0.143798	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	100,022	805,118	905,140	0.173984	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	99,203	417,718	516,921	0.653057	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	364,843	2,935,507	3,300,350	0.507394	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
75.01	03951	SLEEP LAB	1,260	754,140	755,400	0.224992	75.01
75.02	03952	WOUND CENTER	0	419,138	419,138	0.487341	75.02
76.00	03953	CARDIAC REHAB	0	303,032	303,032	0.817079	76.00
76.01	03030	DIABETES EDUCATION	0	21,350	21,350	5.533677	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	9,508,340	9,508,340		88.00
91.00	09100	EMERGENCY	34,965	6,242,533	6,277,498	0.466012	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	7,360	365,100	372,460	1.985832	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	2,538,518	2,538,518		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,528,819	73,784,142	78,312,961		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,528,819	73,784,142	78,312,961		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
75.01	03951	SLEEP LAB	0.000000			75.01
75.02	03952	WOUND CENTER	0.000000			75.02
76.00	03953	CARDIAC REHAB	0.000000			76.00
76.01	03030	DIABETES EDUCATION	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
11/25/2020 8:47 am

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)	Hospital 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	239,031	5,138,959	0.046514	166,802	7,759	50.00
53.00	05300 ANESTHESIOLOGY	2,877	155,840	0.018461	10,963	202	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	98,662	3,331,950	0.029611	64,657	1,915	54.00
54.01	05401 ULTRASOUND	67,792	4,287,650	0.015811	105,596	1,670	54.01
56.00	05600 RADIOISOTOPE	8,036	1,486,303	0.005407	15,330	83	56.00
57.00	05700 CT SCAN	7,551	13,231,933	0.000571	130,095	74	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	145,095	2,924,016	0.049622	7,110	353	58.00
60.00	06000 LABORATORY	101,935	14,384,180	0.007087	346,749	2,457	60.00
65.00	06500 RESPIRATORY THERAPY	16,785	415,783	0.040370	19,585	791	65.00
66.00	06600 PHYSICAL THERAPY	99,439	5,674,267	0.017525	94,363	1,654	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	5,083	633,755	0.008020	11,907	95	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,986	905,140	0.007718	44,936	347	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	4,269	516,921	0.008259	67,852	560	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	32,687	3,300,350	0.009904	102,602	1,016	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	7,762	755,400	0.010275	0	0	75.01
75.02	03952 WOUND CENTER	15,870	419,138	0.037863	0	0	75.02
76.00	03953 CARDIAC REHAB	20,039	303,032	0.066128	0	0	76.00
76.01	03030 DIABETES EDUCATION	3,166	21,350	0.148290	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	374,736	9,508,340	0.039411	0	0	88.00
91.00	09100 EMERGENCY	122,740	6,277,498	0.019552	1,577	31	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	40,825	372,460	0.109609	0	0	92.00
200.00	Total (lines 50 through 199)	1,421,366	74,044,265		1,190,124	19,007	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1349

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
76.01	03030	DIABETES EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1349		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 11/25/2020 8:47 am	
				Title XVIII		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	5,138,959	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	155,840	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC		0	0	0	3,331,950	0.000000	54.00
54.01	05401	ULTRASOUND		0	0	0	4,287,650	0.000000	54.01
56.00	05600	RADIOISOTOPE		0	0	0	1,486,303	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	13,231,933	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	2,924,016	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	14,384,180	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	415,783	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	5,674,267	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	633,755	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	905,140	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS		0	0	0	516,921	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	3,300,350	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00
75.01	03951	SLEEP LAB		0	0	0	755,400	0.000000	75.01
75.02	03952	WOUND CENTER		0	0	0	419,138	0.000000	75.02
76.00	03953	CARDIAC REHAB		0	0	0	303,032	0.000000	76.00
76.01	03030	DIABETES EDUCATION		0	0	0	21,350	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	9,508,340	0.000000	88.00
91.00	09100	EMERGENCY		0	0	0	6,277,498	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	372,460	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	74,044,265		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description			Title XVIII		Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	166,802	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	10,963	0	0	0 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	64,657	0	0	0 54.00
54.01	05401	ULTRASOUND	0.000000	105,596	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0.000000	15,330	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	130,095	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	7,110	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	346,749	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	19,585	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	94,363	0	0	0 66.00
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
69.00	06900	ELECTROCARDIOLOGY	0.000000	11,907	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	44,936	0	0	0 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	67,852	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	102,602	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
75.01	03951	SLEEP LAB	0.000000	0	0	0	0 75.01
75.02	03952	WOUND CENTER	0.000000	0	0	0	0 75.02
76.00	03953	CARDIAC REHAB	0.000000	0	0	0	0 76.00
76.01	03030	DIABETES EDUCATION	0.000000	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
91.00	09100	EMERGENCY	0.000000	1,577	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		1,190,124	0	0	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
11/25/2020 8:47 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.394138	0	1,580,635	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.382007	0	21,833	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.306507	0	831,478	0	0	54.00
54.01	05401	ULTRASOUND	0.104442	0	1,652,179	0	0	54.01
56.00	05600	RADIOISOTOPE	0.264147	0	693,206	0	0	56.00
57.00	05700	CT SCAN	0.021774	0	5,211,465	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.134799	0	1,097,495	0	0	58.00
60.00	06000	LABORATORY	0.175205	0	4,822,682	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.351938	0	164,517	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.265607	0	2,000,721	0	0	66.00
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
69.00	06900	ELECTROCARDIOLOGY	0.143798	0	259,369	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	0	219,591	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.653057	0	76,858	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.507394	0	1,366,628	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.224992	0	309,985	0	0	75.01
75.02	03952	WOUND CENTER	0.487341	0	194,968	0	0	75.02
76.00	03953	CARDIAC REHAB	0.817079	0	120,948	0	0	76.00
76.01	03030	DIABETES EDUCATION	5.533677	0	803	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC						88.00
91.00	09100	EMERGENCY	0.466012	0	2,120,224	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.985832	0	168,660	0	0	92.00
200.00		Subtotal (see instructions)		0	22,914,245	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	22,914,245	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1349		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 11/25/2020 8:47 am	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	622,988	0					50.00
53.00	05300	ANESTHESIOLOGY	8,340	0					53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	254,854	0					54.00
54.01	05401	ULTRASOUND	172,557	0					54.01
56.00	05600	RADIOISOTOPE	183,108	0					56.00
57.00	05700	CT SCAN	113,474	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	147,941	0					58.00
60.00	06000	LABORATORY	844,958	0					60.00
65.00	06500	RESPIRATORY THERAPY	57,900	0					65.00
66.00	06600	PHYSICAL THERAPY	531,406	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	37,297	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,205	0					71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	50,193	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	693,419	0					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
75.01	03951	SLEEP LAB	69,744	0					75.01
75.02	03952	WOUND CENTER	95,016	0					75.02
76.00	03953	CARDIAC REHAB	98,824	0					76.00
76.01	03030	DIABETES EDUCATION	4,444	0					76.01
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC							88.00
91.00	09100	EMERGENCY	988,050	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	334,930	0					92.00
200.00		Subtotal (see instructions)	5,347,648	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	5,347,648	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1349	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 11/25/2020 8:47 am	
Cost Center Description		Title XVIII	Hospital	Cost	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,412	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,450	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)			916	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			455	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)			454	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			28	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			25	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			595	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)			415	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)			260	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			159.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.14	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,275,881	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			4,456	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)			3,979	25.00
26.00	Total swing-bed cost (see instructions)			1,267,491	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,008,390	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)			2,008,390	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,385.10	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			824,135	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)			824,135	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1349

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

Worksheet D-1

Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					307,962	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,132,097	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)					574,817	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					360,126	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					934,943	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)					534	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,385.10	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					739,643	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1349

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

Worksheet D-1

Date/Time Prepared:
11/25/2020 8:47 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	180,817	3,275,881	0.055196	739,643	40,825
91.00	Nursing School cost	0	3,275,881	0.000000	739,643	0
92.00	Allied health cost	0	3,275,881	0.000000	739,643	0
93.00	All other Medical Education	0	3,275,881	0.000000	739,643	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1349	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/25/2020 8:47 am	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		426,050		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.394138	166,802	65,743	50.00
53.00	05300 ANESTHESIOLOGY	0.382007	10,963	4,188	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.306507	64,657	19,818	54.00
54.01	05401 ULTRASOUND	0.104442	105,596	11,029	54.01
56.00	05600 RADIOISOTOPE	0.264147	15,330	4,049	56.00
57.00	05700 CT SCAN	0.021774	130,095	2,833	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.134799	7,110	958	58.00
60.00	06000 LABORATORY	0.175205	346,749	60,752	60.00
65.00	06500 RESPIRATORY THERAPY	0.351938	19,585	6,893	65.00
66.00	06600 PHYSICAL THERAPY	0.265607	94,363	25,063	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.143798	11,907	1,712	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	44,936	7,818	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.653057	67,852	44,311	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.507394	102,602	52,060	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	0.224992	0	0	75.01
75.02	03952 WOUND CENTER	0.487341	0	0	75.02
76.00	03953 CARDIAC REHAB	0.817079	0	0	76.00
76.01	03030 DIABETES EDUCATION	5.533677	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.466012	1,577	735	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.985832	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,190,124	307,962	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,190,124		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1349 Component CCN: 14-Z349	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 11/25/2020 8:47 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.394138	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.382007	0	0	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.306507	13,224	4,053	54.00
54.01	05401 ULTRASOUND	0.104442	6,540	683	54.01
56.00	05600 RADIOISOTOPE	0.264147	0	0	56.00
57.00	05700 CT SCAN	0.021774	18,998	414	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.134799	0	0	58.00
60.00	06000 LABORATORY	0.175205	146,393	25,649	60.00
65.00	06500 RESPIRATORY THERAPY	0.351938	6,599	2,322	65.00
66.00	06600 PHYSICAL THERAPY	0.265607	402,359	106,869	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.143798	2,079	299	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	8,951	1,557	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.653057	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.507394	116,138	58,928	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	03951 SLEEP LAB	0.224992	0	0	75.01
75.02	03952 WOUND CENTER	0.487341	0	0	75.02
76.00	03953 CARDIAC REHAB	0.817079	0	0	76.00
76.01	03030 DIABETES EDUCATION	5.533677	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00	09100 EMERGENCY	0.466012	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.985832	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		721,281	200,774	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		721,281		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-1349	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 11/25/2020 8:47 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,347,648	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,347,648	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,401,124	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)		37,947	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,583,959	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)		1,779,218	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)		1,779,218	30.00
31.00	Primary payer payments		744	31.00
32.00	Subtotal (line 30 minus line 31)		1,778,474	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)		363,463	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		236,251	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		92,877	36.00
37.00	Subtotal (see instructions)		2,014,725	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)		2,014,725	40.00
40.01	Sequestration adjustment (see instructions)		33,646	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		2,495,687	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)		-514,608	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: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
11/25/2020 8:47 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		972,229		2,201,483	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/04/2020	18,605	06/04/2020	294,204	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)		18,605		294,204	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)		990,834		2,495,687	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		32,263		514,608	6.02
7.00	Total Medicare program liability (see instructions)		958,571		1,981,079	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	National Government Services, Inc.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1349

Period:

Worksheet E-1

Component CCN: 14-Z349

From 07/01/2019

Part I

To 06/30/2020

Date/Time Prepared:

11/25/2020 8:47 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,042,287		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/04/2020	261,178		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)		261,178		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,303,465		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		203,967		0	6.02
7.00	Total Medicare program liability (see instructions)		1,099,498		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	National Government Services, Inc.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part II
Date/Time Prepared:
11/25/2020 8:47 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1349 Component CCN:14-Z349	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2 Date/Time Prepared: 11/25/2020 8:47 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		944,292	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)		202,782	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		675	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)		1,147,074	0	8.00
9.00	Primary payer payments (see instructions)			0	9.00
10.00	Subtotal (line 8 minus line 9)		1,147,074	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)		1,147,074	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		28,903	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,118,171	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)		1,118,171	0	19.00
19.01	Sequestration adjustment (see instructions)		18,673	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,303,465	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)		-203,967	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: 14-1349	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part V Date/Time Prepared: 11/25/2020 8:47 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,132,097	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,132,097	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,143,418	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,143,418	19.00
20.00	Deductibles (exclude professional component)		192,768	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		950,650	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		950,650	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		37,232	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		24,201	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,525	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		974,851	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)		974,851	30.00
30.01	Sequestration adjustment (see instructions)		16,280	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		990,834	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)		-32,263	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1349

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

Worksheet G

Date/Time Prepared:
11/25/2020 8:47 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	28,245,988	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,512,185	0	0	0	4.00
5.00	Other receivable	227,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,651,958	0	0	0	6.00
7.00	Inventory	541,690	0	0	0	7.00
8.00	Prepaid expenses	1,353,373	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	373,203	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	34,601,481	0	0	0	11.00
FIXED ASSETS						
12.00	Land	356,334	0	0	0	12.00
13.00	Land improvements	833,714	0	0	0	13.00
14.00	Accumulated depreciation	-679,214	0	0	0	14.00
15.00	Buildings	17,532,318	0	0	0	15.00
16.00	Accumulated depreciation	-13,693,691	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	23,015	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	14,344,577	0	0	0	23.00
24.00	Accumulated depreciation	-11,391,152	0	0	0	24.00
25.00	Minor equipment depreciable	17,834	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	60,527	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,404,262	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,404,737	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)	2,404,737	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,410,480	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	659,602	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,293,769	0	0	0	38.00
39.00	Payroll taxes payable	8,722,326	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,715,110	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,390,807	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,446,080	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)	2,446,080	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,836,887	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	29,573,593				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	29,573,593	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,410,480	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1349

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

Worksheet G-1

Date/Time Prepared:
11/25/2020 8:47 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		28,363,879		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,209,714				2.00
3.00	Total (sum of line 1 and line 2)		29,573,593		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		29,573,593		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,573,593		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1349

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2020 8:47 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,557,718		1,557,718	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	163,620		163,620	5.00
6.00	Swing bed - NF	9,540		9,540	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,730,878		1,730,878	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,730,878		1,730,878	17.00
18.00	Ancillary services	2,763,923	56,478,997	59,242,920	18.00
19.00	Outpatient services	42,325	6,674,390	6,716,715	19.00
20.00	RURAL HEALTH CLINIC	0	9,757,431	9,757,431	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,538,518	2,538,518	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	PRO FEES	58,659	1,404,787	1,463,446	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,595,785	76,854,123	81,449,908	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,010,917		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)		36,010,917		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1349

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

Worksheet G-3

Date/Time Prepared:
11/25/2020 8:47 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,449,908	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,274,192	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,175,716	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,010,917	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,835,201	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	217,297	6.00
7.00	Income from investments	294,138	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	31,563	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	764	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	177,091	22.00
23.00	Governmental appropriations	297,722	23.00
24.00	OTHER MISC REVENUE	459,843	24.00
24.01	340B CONTRACT PHARMACY REVENUE	2,482,407	24.01
24.50	COVID-19 PHE PRF	84,090	24.50
25.00	Total other income (sum of lines 6-24)	4,044,915	25.00
26.00	Total (line 5 plus line 25)	1,209,714	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,209,714	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1349

Period: From 07/01/2019

Worksheet H

HHA CCN: 14-7694

To 06/30/2020

Date/Time Prepared: 11/25/2020 8:47 am

					Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)
	1.00	2.00	3.00	4.00	5.00	6.00
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures			0		0	0
2.00 Capital Related - Movable Equipment			0		0	0
3.00 Plant Operation & Maintenance	0	0	0	0	13,153	13,153
4.00 Transportation	0	0	0	0	0	0
5.00 Administrative and General	306,563	0	0	0	163,837	470,400
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	285,287	0	0	0	0	285,287
7.00 Physical Therapy	194,967	0	0	0	0	194,967
8.00 Occupational Therapy	0	0	0	0	0	0
9.00 Speech Pathology	0	0	0	14,535	0	14,535
10.00 Medical Social Services	0	0	0	0	0	0
11.00 Home Health Aide	0	0	0	0	0	0
12.00 Supplies (see instructions)	0	0	0	0	0	0
13.00 Drugs	0	0	0	0	0	0
14.00 DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0	0	0
16.00 Respiratory Therapy	0	0	0	0	0	0
17.00 Private Duty Nursing	0	0	0	0	0	0
18.00 Clinic	0	0	0	0	0	0
19.00 Health Promotion Activities	0	0	0	0	0	0
20.00 Day Care Program	0	0	0	0	0	0
21.00 Home Delivered Meals Program	0	0	0	0	0	0
22.00 Homemaker Service	0	0	0	0	0	0
23.00 All Others (specify)	0	0	0	0	0	0
23.50 Telemedicine	0	0	0	0	0	0
24.00 Total (sum of lines 1-23)	786,817	0	0	14,535	176,990	978,342
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00 Capital Related - Movable Equipment	0	0	0	0		2.00
3.00 Plant Operation & Maintenance	-823	12,330	0	12,330		3.00
4.00 Transportation	0	0	0	0		4.00
5.00 Administrative and General	-36,873	433,527	0	433,527		5.00
HHA REIMBURSABLE SERVICES						
6.00 Skilled Nursing Care	0	285,287	0	285,287		6.00
7.00 Physical Therapy	-2,247	192,720	0	192,720		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech Pathology	0	14,535	0	14,535		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Home Health Aide	0	0	0	0		11.00
12.00 Supplies (see instructions)	0	0	0	0		12.00
13.00 Drugs	0	0	0	0		13.00
14.00 DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES						
15.00 Home Dialysis Aide Services	0	0	0	0		15.00
16.00 Respiratory Therapy	0	0	0	0		16.00
17.00 Private Duty Nursing	0	0	0	0		17.00
18.00 Clinic	0	0	0	0		18.00
19.00 Health Promotion Activities	0	0	0	0		19.00
20.00 Day Care Program	0	0	0	0		20.00
21.00 Home Delivered Meals Program	0	0	0	0		21.00
22.00 Homemaker Service	0	0	0	0		22.00
23.00 All Others (specify)	0	0	0	0		23.00
23.50 Telemedicine	0	0	0	0		23.50
24.00 Total (sum of lines 1-23)	-39,943	938,399	0	938,399		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1349

Period:

Worksheet H-1

HHA CCN: 14-7694

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
11/25/2020 8:47 amHome Health
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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n			
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)		
		0	1.00	2.00	3.00	4.00	4A.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00	
2.00	Capital Related - Movable Equipment	0		0			0	2.00	
3.00	Plant Operation & Maintenance	12,330	0	0	12,330		0	3.00	
4.00	Transportation	0	0	0	0	0	0	4.00	
5.00	Administrative and General	433,527	0	0	12,330	0	445,857	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	285,287	0	0	0	0	285,287	6.00	
7.00	Physical Therapy	192,720	0	0	0	0	192,720	7.00	
8.00	Occupational Therapy		0	0	0	0	0	8.00	
9.00	Speech Pathology	14,535	0	0	0	0	14,535	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	0	0	0	0	0	0	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine		0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	938,399	0	0	12,330	0	938,399	24.00	
		Administrative & General	Total (cols. 4A + 5)						
		5.00	6.00						
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures							1.00	
2.00	Capital Related - Movable Equipment							2.00	
3.00	Plant Operation & Maintenance							3.00	
4.00	Transportation							4.00	
5.00	Administrative and General	445,857						5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	258,247	543,534					6.00	
7.00	Physical Therapy	174,453	367,173					7.00	
8.00	Occupational Therapy	0	0					8.00	
9.00	Speech Pathology	13,157	27,692					9.00	
10.00	Medical Social Services	0	0					10.00	
11.00	Home Health Aide	0	0					11.00	
12.00	Supplies (see instructions)	0	0					12.00	
13.00	Drugs	0	0					13.00	
14.00	DME	0	0					14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0					15.00	
16.00	Respiratory Therapy	0	0					16.00	
17.00	Private Duty Nursing	0	0					17.00	
18.00	Clinic	0	0					18.00	
19.00	Health Promotion Activities	0	0					19.00	
20.00	Day Care Program	0	0					20.00	
21.00	Home Delivered Meals Program	0	0					21.00	
22.00	Homemaker Service	0	0					22.00	
23.00	All Others (specify)	0	0					23.00	
23.50	Telemedicine	0	0					23.50	
24.00	Total (sum of lines 1-23)		938,399					24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1349

Period:

Worksheet H-1

HHA CCN: 14-7694

From 07/01/2019
To 06/30/2020Part II
Date/Time Prepared:
11/25/2020 8:47 amHome Health
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	1,641	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	1,641	0	-445,857	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	285,287	6.00
7.00	Physical Therapy	0	0	0	0	192,720	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	14,535	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	1,641	0	-445,857	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	12,330	0		25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	7.513711	0.000000		26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
11/25/2020 8:47 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	NORTH CAMPUS BLDG	MVBLE EQUIP			
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	11,450	0	3,981	78,576	94,007	1.00
2.00	Skilled Nursing Care	543,534	0	0	0	81,323	624,857	2.00
3.00	Physical Therapy	367,173	0	0	0	54,936	422,109	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	27,692	0	0	0	0	27,692	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	938,399	11,450	0	3,981	214,835	1,168,665	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00
Cost Center Description		ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	26,478	9,289	25,902	0	2,189	0	1.00
2.00	Skilled Nursing Care	175,997	0	0	0	0	0	2.00
3.00	Physical Therapy	118,892	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	7,800	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	329,167	9,289	25,902	0	2,189	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:

11/25/2020 8:47 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	Home Health Agency I SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	217	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	217	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	158,082	0	158,082				1.00
2.00	Skilled Nursing Care	800,854	0	800,854	91,916	892,770		2.00
3.00	Physical Therapy	541,001	0	541,001	62,092	603,093		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	35,492	0	35,492	4,074	39,566		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,535,429	0	1,535,429	158,082	1,535,429		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.114773			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349
HHA CCN: 14-7694Period:
From 07/01/2019
To 06/30/2020Worksheet H-2
Part II
Date/Time Prepared:
11/25/2020 8:47 amHome Health
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Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	1.01	2.00		5A	5.00	
1.00	Administrative and General	1,641	0	3,982	275,652	0	94,007	1.00
2.00	Skilled Nursing Care	0	0	0	285,287	0	624,857	2.00
3.00	Physical Therapy	0	0	0	192,720	0	422,109	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	27,692	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	0	3,982	753,659		1,168,665	20.00
21.00	Total cost to be allocated	11,450	0	3,981	214,835		329,167	21.00
22.00	Unit cost multiplier	6.977453	0.000000	0.999749	0.285056		0.281661	22.00
Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,641	1,641	0	700	0	1	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,641	1,641	0	700	0	1	20.00
21.00	Total cost to be allocated	9,289	25,902	0	2,189	0	217	21.00
22.00	Unit cost multiplier	5.660573	15.784278	0.000000	3.127143	0.000000	217.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1349

Period:

Worksheet H-2

HHA CCN: 14-7694

From 07/01/2019
To 06/30/2020Part II
Date/Time Prepared:
11/25/2020 8:47 amHome Health
Agency I

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Cost Center Description		NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		13.00	15.00	16.00	17.00	19.00		
1.00	Administrative and General	0	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2019

Part I

To 06/30/2020

Date/Time Prepared:

11/25/2020 8:47 am

Title XVIII

Home Health

PPS

					Agency I			
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	892,770		892,770	4,542	196.56	1.00
2.00	Physical Therapy	3.00	603,093	0	603,093	3,705	162.78	2.00
3.00	Occupational Therapy	4.00	0	0	0	406	0.00	3.00
4.00	Speech Pathology	5.00	39,566	0	39,566	144	274.76	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		1,535,429	0	1,535,429	8,797		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Program Visits				
				Part A	Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		16060	0	178			8.00
8.01	Skilled Nursing Care		41180	0	344			8.01
8.02	Skilled Nursing Care		99914	0	1,953			8.02
9.00	Physical Therapy		16060	0	179			9.00
9.01	Physical Therapy		41180	0	295			9.01
9.02	Physical Therapy		99914	0	1,714			9.02
10.00	Occupational Therapy		16060	0	8			10.00
10.01	Occupational Therapy		41180	0	27			10.01
10.02	Occupational Therapy		99914	0	179			10.02
11.00	Speech Pathology		16060	0	8			11.00
11.01	Speech Pathology		41180	0	7			11.01
11.02	Speech Pathology		99914	0	57			11.02
12.00	Medical Social Services		16060	0	0			12.00
12.01	Medical Social Services		41180	0	0			12.01
12.02	Medical Social Services		99914	0	0			12.02
13.00	Home Health Aide		16060	0	0			13.00
13.01	Home Health Aide		41180	0	0			13.01
13.02	Home Health Aide		99914	0	0			13.02
14.00	Total (sum of lines 8-13)			0	4,949			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		Part A	Part B			Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
								6.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	2,475		0	486,486		1.00
2.00	Physical Therapy	0	2,188		0	356,163		2.00
3.00	Occupational Therapy	0	214		0	0		3.00
4.00	Speech Pathology	0	72		0	19,783		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	4,949		0	862,432		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
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Home Health
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Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
8.00	Limitation Cost Computation								8.00
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B		Subject to Deductibles & Coinsurance	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance			
			6.00	7.00		8.00	9.00		10.00
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	20,271	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	486,486						1.00	
2.00	Physical Therapy	356,163						2.00	
3.00	Occupational Therapy	0						3.00	
4.00	Speech Pathology	19,783						4.00	
5.00	Medical Social Services	0						5.00	
6.00	Home Health Aide	0						6.00	
7.00	Total (sum of lines 1-6)	862,432						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
8.02	Skilled Nursing Care							8.02	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
9.02	Physical Therapy							9.02	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
10.02	Occupational Therapy							10.02	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
11.02	Speech Pathology							11.02	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
12.02	Medical Social Services							12.02	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
13.02	Home Health Aide							13.02	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1349

Period:

Worksheet H-3

HHA CCN: 14-7694

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Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.265607	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.173984	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.507394	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1349 HHA CCN: 14-7694	Period: From 07/01/2019 To 06/30/2020	Worksheet H-4 Part I-II Date/Time Prepared: 11/25/2020 8:47 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0 1.00
2.00	Total charges	0	0	0 2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0 3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0 4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000 5.00
6.00	Total customary charges (see instructions)	0	0	0 6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0 7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0 8.00
9.00	Primary payer amounts	0	0	0 9.00
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0 10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	822,175 11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	33,565 12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	6,528 13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	5,274 14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	9,856 15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0 16.00
17.00	Total Other Payments		0	0 17.00
18.00	DME Payments		0	0 18.00
19.00	Oxygen Payments		0	0 19.00
20.00	Prosthetic and Orthotic Payments		0	0 20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0 21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	877,398 22.00
23.00	Excess reasonable cost (from line 8)		0	0 23.00
24.00	Subtotal (line 22 minus line 23)		0	877,398 24.00
25.00	Coinsurance billed to program patients (from your records)			0 25.00
26.00	Net cost (line 24 minus line 25)		0	877,398 26.00
27.00	Reimbursable bad debts (from your records)			0 27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	877,398 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0 30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0 30.99
31.00	Subtotal (see instructions)		0	877,398 31.00
31.01	Sequestration adjustment (see instructions)		0	15,290 31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0 31.02
32.00	Interim payments (see instructions)		0	862,107 32.00
33.00	Tentative settlement (for contractor use only)		0	0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	1 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0 35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-1349
HHA CCN: 14-7694Period:
From 07/01/2019
To 06/30/2020

Worksheet H-5

Date/Time Prepared:
11/25/2020 8:47 am

		Home Health Agency I		PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		0		862,107
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
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)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		862,107
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)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		1
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		862,108
		Contractor Number		NPR Date (Mo/Day/Yr)	
		0		1.00 2.00	
8.00	Name of Contractor	National Government Services, Inc.		06101	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349

Period:

Worksheet M-1

Component CCN: 14-3464

From 07/01/2019

Date/Time Prepared:

To 06/30/2020

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				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,408,129	834,305	3,242,434	-254,509	2,987,925	1.00
2.00	Physician Assistant	333,361	0	333,361	-450	332,911	2.00
3.00	Nurse Practitioner	606,458	0	606,458	-4,039	602,419	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,209,506	0	1,209,506	0	1,209,506	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	21,138	21,138	-22	21,116	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	4,557,454	855,443	5,412,897	-259,020	5,153,877	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	506,986	506,986	0	506,986	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	166,950	166,950	0	166,950	18.00
19.00	Other Health Care Costs	0	26,416	26,416	0	26,416	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	700,352	700,352	0	700,352	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	4,557,454	1,555,795	6,113,249	-259,020	5,854,229	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	30,994	30,994	25.01
25.02	Chronic Care Management	17,015	0	17,015	0	17,015	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	17,015	0	17,015	30,994	48,009	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	60,856	60,856	-57	60,799	29.00
30.00	Administrative Costs	425,856	146,903	572,759	3,694	576,453	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	425,856	207,759	633,615	3,637	637,252	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,000,325	1,763,554	6,763,879	-224,389	6,539,490	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1349

Period:

Worksheet M-1

Component CCN: 14-3464

From 07/01/2019

Date/Time Prepared:

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		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	2,987,925	1.00
2.00	Physician Assistant	-8,847	324,064	2.00
3.00	Nurse Practitioner	0	602,419	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,209,506	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	21,116	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-8,847	5,145,030	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	506,986	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	166,950	18.00
19.00	Other Health Care Costs	0	26,416	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	700,352	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-8,847	5,845,382	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	30,994	25.01
25.02	Chronic Care Management	0	17,015	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	48,009	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	60,799	29.00
30.00	Administrative Costs	0	576,453	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	637,252	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,847	6,530,643	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1349

Period:

Worksheet M-2

Component CCN: 14-3464

From 07/01/2019
To 06/30/2020Date/Time Prepared:
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		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	7.92	24,353	4,200	33,264	1.00
2.00	Physician Assistant	2.31	7,128	2,100	4,851	2.00
3.00	Nurse Practitioner	5.37	12,619	2,100	11,277	3.00
4.00	Subtotal (sum of lines 1 through 3)	15.60	44,100		49,392	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	0.11	103		103	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)	15.71	44,203		49,495	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)				5,845,382	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				48,009	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				5,893,391	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.991854	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				637,252	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				4,617,558	15.00
16.00	Total overhead (sum of lines 14 and 15)				5,254,810	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				5,254,810	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				5,212,004	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				11,057,386	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3 Date/Time Prepared: 11/25/2020 8:47 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			11,057,386	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			325,637	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			10,731,749	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			49,495	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)			49,495	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			216.82	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		216.82	216.82	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		6,825	5,133	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		1,479,797	1,112,937	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	2,592,734	16.00
16.01	Total program charges (see instructions)(from contractor's records)			2,103,757	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			102,242	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			126,007	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.)			1,856,914	16.04
16.05	Total program cost (see instructions)		0	1,982,921	16.05
17.00	Primary payer amounts			47	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			145,584	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			371,186	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,982,874	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			124,754	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			2,107,628	22.00
23.00	Allowable bad debts (see instructions)			103,736	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			67,428	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			79,408	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)			2,175,056	26.00
26.01	Sequestration adjustment (see instructions)			36,323	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			2,207,016	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)			-68,283	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: 14-1349 Component CCN: 14-3464	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 11/25/2020 8:47 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		5,145,030	5,145,030	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000521	0.002162	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,681	11,124	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		90,224	68,114	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		92,905	79,238	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		5,845,382	5,845,382	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		5,212,004	5,212,004	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.015894	0.013556	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		82,840	70,654	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		175,745	149,892	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		571	2,370	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		307.78	63.25	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		236	824	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		72,636	52,118	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)			325,637	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)			124,754	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1349 Component CCN: 14-3464	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5 Date/Time Prepared: 11/25/2020 8:47 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,936,943	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01		06/18/2020	270,073		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)		270,073		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,207,016		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		0		6.01
6.02	SETTLEMENT TO PROGRAM		68,283		6.02
7.00	Total Medicare program liability (see instructions)		2,138,733		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor	National Government Services, Inc.	06101		8.00