

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet S Parts I-III Date/Time Prepared: 9/30/2020 9:21 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 9/30/2020	Time: 9:21 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLAY COUNTY HOSPITAL (14-1351) for the cost reporting period beginning 03/01/2019 and ending 02/29/2020 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) JENNIFER VENABLE

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

09/30/2020 09:21:05 AM

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	96,657	7,375	0	3,390,823	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	230,044	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		2,060		0	10.00
10.01	RURAL HEALTH CLINIC II	0		0		0	10.01
10.02	RURAL HEALTH CLINIC III	0		0		0	10.02
200.00	Total	0	326,701	9,435	0	3,390,823	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: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 9:21 am
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	1.00	2.00	3.00	4.00						
	Hospital and Hospital Health Care Complex Address:									
1.00	Street: 911 STACY BURK DRIVE	PO Box:			1.00					
2.00	City: FLORA	State: IL	Zip Code: 62839-0280	County: CLAY	2.00					
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CLAY COUNTY HOSPITAL	141351	99914	1	12/21/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CLAY COUNTY SWING BED	14Z351	99914		12/21/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CLAY COUNTY MEDICAL CLINIC	143458	99914		11/29/2005	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOUISVILLE MEDICAL CLINIC	143487	99914		12/18/2006	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CLAY COUNTY HOSPITAL CLAY CITY CLINI	148558	99914		09/02/2016	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					03/01/2019	02/29/2020			20.00
21.00	Type of Control (see instructions)					9				21.00
				1.00	2.00	3.00				

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	N				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet S-2
Part I
Date/Time Prepared:
9/30/2020 9:21 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1351		Period: From 03/01/2019 To 02/29/2020		Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 9:21 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00
					0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 9:21 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	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.	Y	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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	N	N
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 9:21 am
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	142,002	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1351		Period: From 03/01/2019 To 02/29/2020		Worksheet S-2 Part I Date/Time Prepared: 9/30/2020 9:21 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet S-2 Part II Date/Time Prepared: 9/30/2020 9:21 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/02/2020	Y 06/02/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet S-2
Part II
Date/Time Prepared:
9/30/2020 9:21 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.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		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.	ANNA	GUETERSLOH		41.00
42.00	Enter the employer/company name of the cost report preparer.	KERBER, ECK, & BRAECKEL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-529-1040	ANNAG@KEBCPA.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 9:21 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,320	38,681.00	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)		20	7,320	38,681.00	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)		20	7,320	38,681.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		20				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: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 9:21 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)	937	167	1,435			1.00
2.00	HMO and other (see instructions)	68	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	429	0	429			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,366	167	1,864			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)	1,366	167	1,864	0.00	198.10	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	5,334	0	20,614	0.00	35.50	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	233.60	27.00
28.00	Observation Bed Days		106	437			28.00
29.00	Ambulance Trips	1,091					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet S-3
Part I
Date/Time Prepared:
9/30/2020 9:21 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	320	46	444	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	320	46	444	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1351 Component CCN: 14-3458		Period: From 03/01/2019 To 02/29/2020		Worksheet S-8 Date/Time Prepared: 9/30/2020 9:21 am		
				RHC I		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				929 STACY BURK DRIVE				1.00	
				City	State	ZIP Code				
				1.00	2.00	3.00				
2.00	City, State, ZIP Code, County				FLORA		IL 62839		2.00	
						1.00				
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00	
				Grant Award		Date				
				1.00		2.00				
Source of Federal Funds										
4.00	Community Health Center (Section 330(d), PHS Act)								4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00	
7.00	Appalachian Regional Commission								7.00	
8.00	Look-Alikes								8.00	
9.00	OTHER								9.00	
				1.00		2.00				
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00	
				Sunday		Monday		Tuesday		
				from	to	from	to	from		
				1.00	2.00	3.00	4.00	5.00		
Facility hours of operations (1)										
11.00	CLINIC				08:00		17:00		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		3		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number				CLAY COUNTY HOSPITAL CLIN		143458		14.00	
14.01					LOUISVILLE MEDICAL CLINIC		143487		14.01	
14.02					CLAY CITY CLINIC		148558		14.02	
				Y/N	V	XVIII	XIX	Total Visits		
				1.00	2.00	3.00	4.00	5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00	
				County						
				4.00						
2.00	City, State, ZIP Code, County				CLAY				2.00	
				Tuesday	Wednesday	Thursday				
				to	from	to	from	to		
				6.00	7.00	8.00	9.00	10.00		
Facility hours of operations (1)										
11.00	CLINIC				17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1351

Period:

Worksheet S-8

Component CCN: 14-3458

From 03/01/2019
To 02/29/2020Date/Time Prepared:
9/30/2020 9:21 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet S-10 Date/Time Prepared: 9/30/2020 9:21 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)			0.340838 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,574,734		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	14,740,894		6.00
7.00	Medicaid cost (line 1 times line 6)	5,024,257		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)	2,449,523		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	134,152		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	347,652		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,449,523		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)	644,272	2,675,511	3,319,783 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	219,592	2,675,511	2,895,103 21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,876	15,100	16,976 22.00
23.00	Cost of charity care (line 21 minus line 22)	217,716	2,660,411	2,878,127 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)	2,794,067		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	754,896		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,161,378		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,632,689		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	962,964		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,841,091		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,290,614		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet A

Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		478,618	478,618	71,131	549,749	1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT		7,834	7,834	123,449	131,283	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		530,450	530,450	190,599	721,049	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	175,933	3,786,675	3,962,608	0	3,962,608	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,432,937	2,649,632	4,082,569	-203,980	3,878,589	5.00
7.00	00700	OPERATION OF PLANT	254,163	471,103	725,266	0	725,266	7.00
7.01	00701	RHC UTILITY EXPENSE	0	40,448	40,448	0	40,448	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,010	92,762	94,772	0	94,772	8.00
9.00	00900	HOUSEKEEPING	304,912	38,662	343,574	0	343,574	9.00
10.00	01000	DIETARY	332,642	147,211	479,853	-302,542	177,311	10.00
11.00	01100	CAFETERIA	0	0	0	300,513	300,513	11.00
13.00	01300	NURSING ADMINISTRATION	483,614	26,978	510,592	0	510,592	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,550	27,148	57,698	0	57,698	14.00
15.00	01500	PHARMACY	191,862	292,250	484,112	0	484,112	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	395,595	114,798	510,393	0	510,393	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,083,280	745,919	1,829,199	0	1,829,199	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	301,998	101,824	403,822	6,784	410,606	50.00
53.00	05300	ANESTHESIOLOGY	0	342,784	342,784	-6,784	336,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	489,567	901,925	1,391,492	-39,138	1,352,354	54.00
60.00	06000	LABORATORY	600,196	977,612	1,577,808	-140,032	1,437,776	60.00
65.00	06500	RESPIRATORY THERAPY	393,435	69,341	462,776	-78,687	384,089	65.00
66.00	06600	PHYSICAL THERAPY	538,370	35,056	573,426	0	573,426	66.00
69.00	06900	ELECTROCARDIOLOGY	0	37,537	37,537	59,015	96,552	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	57,472	57,472	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	349,059	349,059	-12,090	336,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,090	12,090	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	101,735	692,818	794,553	0	794,553	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	495,055	495,055	0	495,055	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,714,690	360,879	3,075,569	-160,817	2,914,752	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	123,017	123,017	90.00
91.00	09100	EMERGENCY	694,949	1,076,606	1,771,555	0	1,771,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	809,529	111,312	920,841	0	920,841	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,331,967	15,002,296	26,334,263	0	26,334,263	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,925	8,666	33,591	0	33,591	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	11,356,892	15,010,962	26,367,854	0	26,367,854	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet A

Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	549,749	1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	0	131,283	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	721,049	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-228,787	3,733,821	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-252,538	3,626,051	5.00
7.00	00700	OPERATION OF PLANT	0	725,266	7.00
7.01	00701	RHC UTILITY EXPENSE	0	40,448	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	94,772	8.00
9.00	00900	HOUSEKEEPING	0	343,574	9.00
10.00	01000	DIETARY	0	177,311	10.00
11.00	01100	CAFETERIA	-142,324	158,189	11.00
13.00	01300	NURSING ADMINISTRATION	0	510,592	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,698	14.00
15.00	01500	PHARMACY	-139,611	344,501	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,839	502,554	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,829,199	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	410,606	50.00
53.00	05300	ANESTHESIOLOGY	-336,000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,352,354	54.00
60.00	06000	LABORATORY	0	1,437,776	60.00
65.00	06500	RESPIRATORY THERAPY	0	384,089	65.00
66.00	06600	PHYSICAL THERAPY	0	573,426	66.00
69.00	06900	ELECTROCARDIOLOGY	0	96,552	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	57,472	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	336,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	12,090	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-179,311	615,242	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	495,055	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,914,752	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
90.00	09000	CLINIC	0	123,017	90.00
91.00	09100	EMERGENCY	0	1,771,555	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	920,841	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,286,410	25,047,853	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	33,591	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,286,410	25,081,444	200.00

RECLASSIFICATIONS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-6

Date/Time Prepared:
9/30/2020 9:21 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRICIATION					
1.00	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	92,902	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	92,902		
	B - RESPIRATORY THERAPY					
1.00	ELECTROCARDIOLOGY	69.00	59,015	0	1.00	
2.00	ELECTROENCEPHALOGRAPHY	70.00	19,672	0	2.00	
	TOTALS		78,687	0		
	C - INSURANCE EXPENSE					
1.00	NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	30,547	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	29,699	2.00	
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	143,734	3.00	
	TOTALS		0	203,980		
	D - OPERATING ROOM					
1.00	OPERATING ROOM	50.00	0	6,784	1.00	
	TOTALS		0	6,784		
	E - RECLASS PORTION OF DIETARY TO CAFE					
1.00	CAFETERIA	11.00	209,205	92,584	1.00	
	TOTALS		209,205	92,584		
	F - RECLASS IMPLANTABLE DEVICE COST					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12,090	1.00	
	TOTALS		0	12,090		
	G - DIEBETIES EDUCATION					
1.00	CLINIC	90.00	108,427	14,590	1.00	
	TOTALS		108,427	14,590		
	H - RECLASS PRO FEES FROM RHC TO EEG					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	37,800	1.00	
	TOTALS		0	37,800		
	I - CONSOLIDATE EQUIPMENT RENTALS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	181,199	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	181,199		
500.00	Grand Total: Increases		396,319	641,929	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-6

Date/Time Prepared:
9/30/2020 9:21 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRICIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	72,603	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	20,299	9		2.00
	TOTALS		0	92,902			
	B - RESPIRATORY THERAPY						
1.00	RESPIRATORY THERAPY	65.00	78,687	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		78,687	0			
	C - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	203,980	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	203,980			
	D - OPERATING ROOM						
1.00	ANESTHESIOLOGY	53.00	0	6,784	0		1.00
	TOTALS		0	6,784			
	E - RECLASS PORTION OF DIETARY TO CAFE						
1.00	DIETARY	10.00	209,205	92,584	0		1.00
	TOTALS		209,205	92,584			
	F - RECLASS IMPLANTABLE DEVICE COST						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	12,090	0		1.00
	TOTALS		0	12,090			
	G - DIEBETIES EDUCATION						
1.00	RURAL HEALTH CLINIC	88.00	108,427	14,590	0		1.00
	TOTALS		108,427	14,590			
	H - RECLASS PRO FEES FROM RHC TO EEG						
1.00	RURAL HEALTH CLINIC	88.00	0	37,800	0		1.00
	TOTALS		0	37,800			
	I - CONSOLIDATE EQUIPMENT RENTALS						
1.00	DIETARY	10.00	0	753	10		1.00
2.00	CAFETERIA	11.00	0	1,276	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	39,138	0		3.00
4.00	LABORATORY	60.00	0	140,032	0		4.00
	TOTALS		0	181,199			
500.00	Grand Total: Decreases		396,319	641,929			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet A-7
Part I
Date/Time Prepared:
9/30/2020 9:21 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	135,111	0	0	0	0	1.00	
2.00	Land Improvements	351,667	0	0	0	0	2.00	
3.00	Buildings and Fixtures	13,438,329	51,536	0	51,536	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	8,756,045	395,764	0	395,764	8,175	6.00	
7.00	HIT designated Assets	1,573,806	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	24,254,958	447,300	0	447,300	8,175	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	24,254,958	447,300	0	447,300	8,175	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	135,111	0				1.00	
2.00	Land Improvements	351,667	0				2.00	
3.00	Buildings and Fixtures	13,489,865	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	9,143,634	0				6.00	
7.00	HIT designated Assets	1,573,806	0				7.00	
8.00	Subtotal (sum of lines 1-7)	24,694,083	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	24,694,083	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet A-7
Part II
Date/Time Prepared:
9/30/2020 9:21 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	478,618	0	0	0	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	0	7,834	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	500,260	30,190	0	0	0	2.00
3.00	Total (sum of lines 1-2)	978,878	30,190	0	0	7,834	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	478,618				1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	7,834				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	530,450				2.00
3.00	Total (sum of lines 1-2)	0	1,016,902				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet A-7
Part III
Date/Time Prepared:
9/30/2020 9:21 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	13,976,643	0	13,976,643	0.565992	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	10,717,440	0	10,717,440	0.434008	0	2.00
3.00	Total (sum of lines 1-2)	24,694,083	0	24,694,083	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	406,015	0	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	0	0	92,902	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	479,961	211,389	2.00
3.00	Total (sum of lines 1-2)	0	0	0	978,878	211,389	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	143,734	0	0	549,749	1.00
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	0	30,547	7,834	0	131,283	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	29,699	0	0	721,049	2.00
3.00	Total (sum of lines 1-2)	0	203,980	7,834	0	1,402,081	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-8

Date/Time Prepared:
9/30/2020 9:21 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	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP RHC REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-1,453	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		0		0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-320	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	-140,942	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	-35	ADMINISTRATIVE & GENERAL	5.00	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	-7,839	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines	B	-1,382	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP RHC REL COSTS-BLDG & FIXT			0NEW CAP RHC REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-8

Date/Time Prepared:
9/30/2020 9:21 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	2.00	3.00	4.00	5.00			
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	MISCELLANEOUS REVENUE	B	-4,001	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PUBLIC RELATIONS	A	-238,119	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING EXPENSE	A	-8,610	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	CRNA EXPENSE	A	-336,000	ANESTHESIOLOGY	53.00	0	37.00
38.00	EMPLOYEE BENEFITS LAB TESTS	A	-58,517	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	EMPLOYEE HEALTH INSURANCE REIMBURSEMENT	B	-120,976	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	PENSION DIFFERENTIAL	A	-49,294	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	42.00
43.00	340B EXPENSES	A	-179,311	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
44.00	340B EXPENSES	A	-139,611	PHARMACY	15.00	0	44.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,286,410				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: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet A-8-2

Date/Time Prepared:
9/30/2020 9:21 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	635,454	0	635,454	0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	24,000	0	24,000	0	0	2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	37,800	0	37,800	0	0	5.00
6.00	0.00	AGGREGATE-	0	0	0	0	0	6.00
7.00	91.00	AGGREGATE-EMERGENCY	961,691	0	961,691	0	0	7.00
8.00	0.00	AGGREGATE-	0	0	0	0	0	8.00
9.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,658,945	0	1,658,945		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00	0.00	AGGREGATE-	0	0	0	0	0	6.00
7.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	7.00
8.00	0.00	AGGREGATE-	0	0	0	0	0	8.00
9.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0		3.00
4.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0		4.00
5.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0		5.00
6.00	0.00	AGGREGATE-	0	0	0	0		6.00
7.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0		7.00
8.00	0.00	AGGREGATE-	0	0	0	0		8.00
9.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet B
Part I
Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NEW CAP RHC REL COSTS-BLDG & FIXT	MVBLE EQUIP	
			0	1.00	1.01	2.00	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	549,749	549,749			1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	131,283	0	131,283		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	721,049			721,049	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,733,821	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,626,051	284,794	0	366,406	5.00
7.00	00700	OPERATION OF PLANT	725,266	4,082	0	5,252	7.00
7.01	00701	RHC UTILITY EXPENSE	40,448	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	94,772	906	0	1,166	8.00
9.00	00900	HOUSEKEEPING	343,574	2,067	0	2,659	9.00
10.00	01000	DIETARY	177,311	9,519	0	12,247	10.00
11.00	01100	CAFETERIA	158,189	3,054	0	3,929	11.00
13.00	01300	NURSING ADMINISTRATION	510,592	2,555	0	3,288	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,698	4,439	0	5,711	14.00
15.00	01500	PHARMACY	344,501	4,276	0	5,501	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	502,554	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,829,199	62,184	0	80,003	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	410,606	41,405	0	53,270	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,352,354	30,583	0	39,347	54.00
60.00	06000	LABORATORY	1,437,776	12,197	0	15,691	60.00
65.00	06500	RESPIRATORY THERAPY	384,089	10,710	0	13,779	65.00
66.00	06600	PHYSICAL THERAPY	573,426	0	10,357	0	66.00
69.00	06900	ELECTROCARDIOLOGY	96,552	3,421	0	4,401	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	57,472	3,411	1,632	4,388	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	336,969	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,090	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	615,242	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	495,055	26,287	0	33,819	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,914,752	0	111,936	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	123,017	0	495	0	90.00
91.00	09100	EMERGENCY	1,771,555	28,455	0	36,609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	920,841	12,665	0	16,294	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,047,853	547,010	124,420	703,760	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,739	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	33,591	0	6,863	17,289	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,081,444	549,749	131,283	721,049	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	
			4A	5.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						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	4,755,773	4,755,773				5.00
7.00	00700	OPERATION OF PLANT	819,476	191,740	1,011,216			7.00
7.01	00701	RHC UTILITY EXPENSE	40,448	9,464		49,912		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	97,515	22,816	3,512		123,843	8.00
9.00	00900	HOUSEKEEPING	450,124	105,320	8,011			9.00
10.00	01000	DIETARY	240,298	56,225	36,898			10.00
11.00	01100	CAFETERIA	235,035	54,993	11,839			11.00
13.00	01300	NURSING ADMINISTRATION	677,935	158,623	9,905			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,050	18,262	17,206			14.00
15.00	01500	PHARMACY	418,349	97,885	16,575			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	634,661	148,497				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,333,142	545,906	241,044	0	123,843	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	606,132	141,822	160,499	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,585,772	371,037	118,549	0	0	54.00
60.00	06000	LABORATORY	1,666,096	389,831	47,277	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	513,687	120,192	41,516	0	0	65.00
66.00	06600	PHYSICAL THERAPY	763,569	178,659	0	3,938	0	66.00
69.00	06900	ELECTROCARDIOLOGY	124,082	29,033	13,260	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	73,472	17,191	13,220	621	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	336,969	78,844	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,090	2,829	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	649,216	151,903	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	555,161	129,896	101,895	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,897,033	911,817	0	42,556	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	159,721	37,371	0	188	0	90.00
91.00	09100	EMERGENCY	2,068,694	484,031	110,301	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,220,138	285,487	49,093	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	25,012,638	4,739,674	1,000,600	47,303	123,843	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,739	641	10,616	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	66,067	15,458	0	2,609	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,081,444	4,755,773	1,011,216	49,912	123,843	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1351

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						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
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	563,455					9.00
10.00	01000	DIETARY	11,245	344,666				10.00
11.00	01100	CAFETERIA	3,608	0	305,475			11.00
13.00	01300	NURSING ADMINISTRATION	3,019	0	19,080	868,562		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,244	0	1,205	5,890	125,857	14.00
15.00	01500	PHARMACY	5,051	0	7,570	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,461	302,690	42,739	208,846	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,914	0	11,915	58,222	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,129	0	19,315	94,383	0	54.00
60.00	06000	LABORATORY	14,408	0	23,680	115,711	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,652	0	12,418	60,680	0	65.00
66.00	06600	PHYSICAL THERAPY	20,145	0	21,240	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,041	0	2,328	11,377	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,204	0	776	3,793	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	121,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,363	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,014	19,613	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	31,054	41,976	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	217,727	0	75,561	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	962	0	4,278	0	0	90.00
91.00	09100	EMERGENCY	33,616	0	27,418	133,979	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,514	0	31,938	156,068	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	530,994	344,666	305,475	868,562	125,857	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,235	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,226	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	563,455	344,666	305,475	868,562	125,857	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						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
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	545,430					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	783,158				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	38,108	0	3,909,779	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	48,818	0	1,076,322	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	209,128	0	2,434,313	0	54.00
60.00	06000	LABORATORY	0	131,634	0	2,388,637	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,701	0	774,846	0	65.00
66.00	06600	PHYSICAL THERAPY	0	36,308	0	1,023,859	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,104	0	199,225	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,717	0	118,994	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	34,760	0	572,067	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	566	0	19,848	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	545,430	76,409	0	1,446,585	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	15,361	0	875,343	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	43,837	0	5,188,531	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	22	0	202,542	0	90.00
91.00	09100	EMERGENCY	0	82,743	0	2,940,782	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	33,942	0	1,779,180	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	545,430	783,158	0	24,950,853	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	17,231	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	113,360	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	545,430	783,158	0	25,081,444	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	NEW CAP RHC REL COSTS-BLDG & FIXT	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
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	RHC UTILITY EXPENSE	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
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
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
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

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	NEW CAP RHC REL COSTS-BLDG & FIXT	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	NEW CAP RHC REL COSTS-BLDG & FIXT					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	0	284,794	0	366,406	651,200 5.00
7.00	00700	OPERATION OF PLANT	0	4,082	0	5,252	9,334 7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	0	0 7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	906	0	1,166	2,072 8.00
9.00	00900	HOUSEKEEPING	0	2,067	0	2,659	4,726 9.00
10.00	01000	DIETARY	0	9,519	0	12,247	21,766 10.00
11.00	01100	CAFETERIA	0	3,054	0	3,929	6,983 11.00
13.00	01300	NURSING ADMINISTRATION	0	2,555	0	3,288	5,843 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,439	0	5,711	10,150 14.00
15.00	01500	PHARMACY	0	4,276	0	5,501	9,777 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	62,184	0	80,003	142,187 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	41,405	0	53,270	94,675 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,583	0	39,347	69,930 54.00
60.00	06000	LABORATORY	0	12,197	0	15,691	27,888 60.00
65.00	06500	RESPIRATORY THERAPY	0	10,710	0	13,779	24,489 65.00
66.00	06600	PHYSICAL THERAPY	0	0	10,357	0	10,357 66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,421	0	4,401	7,822 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,411	1,632	4,388	9,431 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	26,287	0	33,819	60,106 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	111,936	0	111,936 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02
90.00	09000	CLINIC	0	0	495	0	495 90.00
91.00	09100	EMERGENCY	0	28,455	0	36,609	65,064 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	12,665	0	16,294	28,959 95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	547,010	124,420	703,760	1,375,190 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,739	0	0	2,739 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,863	17,289	24,152 192.00
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	549,749	131,283	721,049	1,402,081 202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	
			4.00	5.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						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	651,200				5.00
7.00	00700	OPERATION OF PLANT	0	26,254	35,588			7.00
7.01	00701	RHC UTILITY EXPENSE	0	1,296	0	1,296		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,124	124	0	5,320	8.00
9.00	00900	HOUSEKEEPING	0	14,421	282	0	0	9.00
10.00	01000	DIETARY	0	7,699	1,299	0	0	10.00
11.00	01100	CAFETERIA	0	7,530	417	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,720	349	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,501	606	0	0	14.00
15.00	01500	PHARMACY	0	13,403	583	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,333	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	74,749	8,481	0	5,320	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	19,419	5,648	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,805	4,172	0	0	54.00
60.00	06000	LABORATORY	0	53,378	1,664	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,458	1,461	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	24,463	0	102	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,975	467	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,354	465	16	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,796	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	387	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,800	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	17,786	3,586	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	124,859	0	1,105	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	5,117	0	5	0	90.00
91.00	09100	EMERGENCY	0	66,277	3,882	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	39,091	1,728	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	648,995	35,214	1,228	5,320	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	88	374	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,117	0	68	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	651,200	35,588	1,296	5,320	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						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
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	19,429					9.00
10.00	01000	DIETARY	388	31,152				10.00
11.00	01100	CAFETERIA	124	0	15,054			11.00
13.00	01300	NURSING ADMINISTRATION	104	0	940	28,956		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	181	0	59	196	13,693	14.00
15.00	01500	PHARMACY	174	0	373	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,533	27,358	2,106	6,965	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,687	0	587	1,941	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,246	0	952	3,146	0	54.00
60.00	06000	LABORATORY	497	0	1,167	3,857	0	60.00
65.00	06500	RESPIRATORY THERAPY	436	0	612	2,023	0	65.00
66.00	06600	PHYSICAL THERAPY	695	0	1,047	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	139	0	115	379	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	248	0	38	126	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	475	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	198	654	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,071	3,794	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,507	0	3,724	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	33	0	211	0	0	90.00
91.00	09100	EMERGENCY	1,159	0	1,351	4,466	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	87	0	1,574	5,203	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,309	31,152	15,054	28,956	13,693	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	112	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,008	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,429	31,152	15,054	28,956	13,693	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						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
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	24,310					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,333				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	990	0	270,689	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,269	0	125,226	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,414	0	135,665	0	54.00
60.00	06000	LABORATORY	0	3,421	0	91,872	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	356	0	45,835	0	65.00
66.00	06600	PHYSICAL THERAPY	0	944	0	37,608	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	393	0	13,290	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	71	0	12,749	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	903	0	24,917	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15	0	877	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,310	1,986	0	47,948	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	399	0	86,742	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,139	0	250,270	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	1	0	5,862	0	90.00
91.00	09100	EMERGENCY	0	2,150	0	144,349	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	882	0	77,524	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,310	20,333	0	1,371,423	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	3,313	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	27,345	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,310	20,333	0	1,402,081	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1351

Period:
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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	NEW CAP RHC REL COSTS-BLDG & FIXT	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
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	RHC UTILITY EXPENSE	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
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
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
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: 14-1351

Period:
From 03/01/2019
To 02/29/2020

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Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	NEW CAP RHC REL COSTS-BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
			1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	53,999					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT	0	21,232				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			55,050			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	11,180,959		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,974	0	27,974	1,432,937	-4,755,773	5.00
7.00	00700	OPERATION OF PLANT	401	0	401	254,163	0	7.00
7.01	00701	RHC UTILITY EXPENSE	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	89	0	89	2,010	0	8.00
9.00	00900	HOUSEKEEPING	203	0	203	304,912	0	9.00
10.00	01000	DIETARY	935	0	935	123,437	0	10.00
11.00	01100	CAFETERIA	300	0	300	209,205	0	11.00
13.00	01300	NURSING ADMINISTRATION	251	0	251	483,614	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	436	0	436	30,550	0	14.00
15.00	01500	PHARMACY	420	0	420	191,862	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	395,595	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,108	0	6,108	1,083,280	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,067	0	4,067	301,998	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,004	0	3,004	489,567	0	54.00
60.00	06000	LABORATORY	1,198	0	1,198	600,196	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,052	0	1,052	314,748	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,675	0	538,370	0	66.00
69.00	06900	ELECTROCARDIOLOGY	336	0	336	59,015	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	335	264	335	19,672	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	101,735	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582	0	2,582	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	18,103	0	2,606,263	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	80	0	108,427	0	90.00
91.00	09100	EMERGENCY	2,795	0	2,795	694,949	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,244	0	1,244	809,529	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,730	20,122	53,730	11,156,034	-4,755,773	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	269	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,110	1,320	24,925	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	549,749	131,283	721,049	3,733,821		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.180726	6.183261	13.098074	0.333945		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: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	RHC UTILITY EXPENSE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	
		5.00	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT					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	20,325,671				5.00
7.00	00700	OPERATION OF PLANT	819,476	25,624			7.00
7.01	00701	RHC UTILITY EXPENSE	40,448	0	21,232		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	97,515	89	0	1,435	8.00
9.00	00900	HOUSEKEEPING	450,124	203	0	0	9.00
10.00	01000	DIETARY	240,298	935	0	0	10.00
11.00	01100	CAFETERIA	235,035	300	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	677,935	251	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	78,050	436	0	0	14.00
15.00	01500	PHARMACY	418,349	420	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	634,661	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,333,142	6,108	0	1,435	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	606,132	4,067	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,585,772	3,004	0	0	54.00
60.00	06000	LABORATORY	1,666,096	1,198	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	513,687	1,052	0	0	65.00
66.00	06600	PHYSICAL THERAPY	763,569	0	1,675	0	66.00
69.00	06900	ELECTROCARDIOLOGY	124,082	336	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	73,472	335	264	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	336,969	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,090	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	649,216	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	555,161	2,582	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,897,033	0	18,103	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	159,721	0	80	0	90.00
91.00	09100	EMERGENCY	2,068,694	2,795	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,220,138	1,244	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,256,865	25,355	20,122	1,435	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,739	269	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	66,067	0	1,110	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,755,773	1,011,216	49,912	123,843	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.233979	39.463628	2.350791	86.301742	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	651,200	35,588	1,296	5,320	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.032038	1.388854	0.061040	3.707317	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: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			DIETARY (EQV PATIENT DAY)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT						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
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	RHC UTILITY EXPENSE						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,634					10.00
11.00	01100	CAFETERIA	0	7,742,779				11.00
13.00	01300	NURSING ADMINISTRATION	0	483,614	4,505,239			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,550	30,550	348,786		14.00
15.00	01500	PHARMACY	0	191,862	0	0	445,590	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,435	1,083,280	1,083,280	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	301,998	301,998	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	489,567	489,567	0	0	54.00
60.00	06000	LABORATORY	0	600,196	600,196	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	314,748	314,748	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	538,370	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	59,015	59,015	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	19,672	19,672	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	336,696	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,090	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	101,735	101,735	0	445,590	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	199	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,915,267	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	108,427	0	0	0	90.00
91.00	09100	EMERGENCY	0	694,949	694,949	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	809,529	809,529	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,634	7,742,779	4,505,239	348,786	445,590	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	344,666	305,475	868,562	125,857	545,430	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	210.933905	0.039453	0.192789	0.360843	1.224062	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	31,152	15,054	28,956	13,693	24,310	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	19.064871	0.001944	0.006427	0.039259	0.054557	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: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet B-1

Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT		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
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	RHC UTILITY EXPENSE		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	73,204,518	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,562,153	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4,563,300	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,546,642	54.00
60.00	06000	LABORATORY	12,304,565	60.00
65.00	06500	RESPIRATORY THERAPY	1,280,702	65.00
66.00	06600	PHYSICAL THERAPY	3,393,912	66.00
69.00	06900	ELECTROCARDIOLOGY	1,411,890	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	254,000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,249,192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,142,386	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,435,865	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	4,097,651	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	88.02
90.00	09000	CLINIC	2,100	90.00
91.00	09100	EMERGENCY	7,734,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	3,172,780	95.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	73,204,518	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	783,158	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010698	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,333	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000278	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: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 9:21 am

			Title XVIII	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,909,779		3,909,779	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,076,322		1,076,322	0
53.00	05300	ANESTHESIOLOGY	0		0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,434,313		2,434,313	0
60.00	06000	LABORATORY	2,388,637		2,388,637	0
65.00	06500	RESPIRATORY THERAPY	774,846	0	774,846	0
66.00	06600	PHYSICAL THERAPY	1,023,859	0	1,023,859	0
69.00	06900	ELECTROCARDIOLOGY	199,225		199,225	0
70.00	07000	ELECTROENCEPHALOGRAPHY	118,994		118,994	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	572,067		572,067	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,848		19,848	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,446,585		1,446,585	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	875,343		875,343	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,188,531		5,188,531	0
88.01	08801	RURAL HEALTH CLINIC II	0		0	0
88.02	08802	RURAL HEALTH CLINIC III	0		0	0
90.00	09000	CLINIC	202,542		202,542	0
91.00	09100	EMERGENCY	2,940,782		2,940,782	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	742,533		742,533	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,779,180		1,779,180	0
200.00		Subtotal (see instructions)	25,693,386	0	25,693,386	0
201.00		Less Observation Beds	742,533		742,533	0
202.00		Total (see instructions)	24,950,853	0	24,950,853	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 9:21 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	1,751,160		1,751,160		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	699,835	3,863,465	4,563,300	0.235865	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	666,681	18,879,961	19,546,642	0.124539	0.000000
60.00	06000	LABORATORY	1,063,348	11,241,217	12,304,565	0.194126	0.000000
65.00	06500	RESPIRATORY THERAPY	752,395	528,307	1,280,702	0.605017	0.000000
66.00	06600	PHYSICAL THERAPY	359,514	3,034,398	3,393,912	0.301675	0.000000
69.00	06900	ELECTROCARDIOLOGY	36,538	1,375,352	1,411,890	0.141105	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	254,000	254,000	0.468480	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,603,357	1,645,835	3,249,192	0.176064	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,354	27,560	52,914	0.375099	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,169,821	4,972,565	7,142,386	0.202535	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,435,865	1,435,865	0.609628	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,097,651	4,097,651		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	0	2,100	2,100	96.448571	0.000000
91.00	09100	EMERGENCY	81,987	7,652,479	7,734,466	0.380218	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,620	1,806,373	1,810,993	0.410014	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	3,172,780	3,172,780	0.560764	0.000000
200.00		Subtotal (see instructions)	9,214,610	63,989,908	73,204,518		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,214,610	63,989,908	73,204,518		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 9:21 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
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
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
88.02	08802 RURAL HEALTH CLINIC III				88.02
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 9:21 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,909,779		3,909,779	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,076,322		1,076,322	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,434,313		2,434,313	0	0	54.00
60.00	06000	LABORATORY	2,388,637		2,388,637	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	774,846	0	774,846	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,023,859	0	1,023,859	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	199,225		199,225	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	118,994		118,994	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	572,067		572,067	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,848		19,848	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,446,585		1,446,585	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	875,343		875,343	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,188,531		5,188,531	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0		0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0		0	0	0	88.02
90.00	09000	CLINIC	202,542		202,542	0	0	90.00
91.00	09100	EMERGENCY	2,940,782		2,940,782	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	742,533		742,533	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,779,180		1,779,180	0	0	95.00
200.00		Subtotal (see instructions)	25,693,386	0	25,693,386	0	0	200.00
201.00		Less Observation Beds	742,533		742,533	0	0	201.00
202.00		Total (see instructions)	24,950,853	0	24,950,853	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 9:21 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,751,160		1,751,160		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	699,835	3,863,465	4,563,300	0.235865	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	666,681	18,879,961	19,546,642	0.124539	0.000000
60.00	06000	LABORATORY	1,063,348	11,241,217	12,304,565	0.194126	0.000000
65.00	06500	RESPIRATORY THERAPY	752,395	528,307	1,280,702	0.605017	0.000000
66.00	06600	PHYSICAL THERAPY	359,514	3,034,398	3,393,912	0.301675	0.000000
69.00	06900	ELECTROCARDIOLOGY	36,538	1,375,352	1,411,890	0.141105	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	254,000	254,000	0.468480	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,603,357	1,645,835	3,249,192	0.176064	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,354	27,560	52,914	0.375099	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	2,169,821	4,972,565	7,142,386	0.202535	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,435,865	1,435,865	0.609628	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,097,651	4,097,651	1.266221	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000
90.00	09000	CLINIC	0	2,100	2,100	96.448571	0.000000
91.00	09100	EMERGENCY	81,987	7,652,479	7,734,466	0.380218	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,620	1,806,373	1,810,993	0.410014	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	3,172,780	3,172,780	0.560764	0.000000
200.00		Subtotal (see instructions)	9,214,610	63,989,908	73,204,518		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,214,610	63,989,908	73,204,518		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet C
Part I
Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000			88.02
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
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: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part II
Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	125,226	4,563,300	0.027442	291,517	8,000
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	135,665	19,546,642	0.006941	264,868	1,838
60.00	06000	LABORATORY	91,872	12,304,565	0.007466	607,328	4,534
65.00	06500	RESPIRATORY THERAPY	45,835	1,280,702	0.035789	429,304	15,364
66.00	06600	PHYSICAL THERAPY	37,608	3,393,912	0.011081	110,788	1,228
69.00	06900	ELECTROCARDIOLOGY	13,290	1,411,890	0.009413	20,321	191
70.00	07000	ELECTROENCEPHALOGRAPHY	12,749	254,000	0.050193	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,917	3,249,192	0.007669	902,354	6,920
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	877	52,914	0.016574	12,350	205
73.00	07300	DRUGS CHARGED TO PATIENTS	47,948	7,142,386	0.006713	1,139,643	7,650
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	86,742	1,435,865	0.060411	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	250,270	4,097,651	0.061076	0	0
88.01	08801	RURAL HEALTH CLINIC II	0	0	0.000000	0	0
88.02	08802	RURAL HEALTH CLINIC III	0	0	0.000000	0	0
90.00	09000	CLINIC	5,862	2,100	2.791429	0	0
91.00	09100	EMERGENCY	144,349	7,734,466	0.018663	3,537	66
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	51,409	1,810,993	0.028387	3,132	89
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)	1,074,619	68,280,578		3,785,142	46,085

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 9:21 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	4,563,300	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,546,642	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,304,565	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,280,702	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,393,912	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,411,890	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	254,000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,249,192	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,914	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,142,386	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,435,865	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,097,651	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
90.00	09000	CLINIC	0	0	0	2,100	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	7,734,466	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,810,993	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	68,280,578		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 9:21 am

				Title XVIII		Hospital	Cost			
	Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
				9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	291,517	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	264,868	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.000000	607,328	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	429,304	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	110,788	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	20,321	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	902,354	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,350	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,139,643	0	0	0	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	0	88.02	
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	3,537	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,132	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00	
200.00		Total (lines 50 through 199)		3,785,142	0	0	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part V
Date/Time Prepared:
9/30/2020 9:21 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	0.235865	0	1,740,784	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124539	0	8,079,439	0	0	54.00	
60.00	06000	LABORATORY	0.194126	0	5,160,500	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.605017	0	127,005	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.301675	0	1,308,593	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.141105	0	733,951	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.468480	0	254,000	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176064	0	899,742	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375099	0	27,195	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202535	0	2,292,653	0	0	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.609628	0	1,349,604	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02	
90.00	09000	CLINIC	96.448571	0	2,098	0	0	90.00	
91.00	09100	EMERGENCY	0.380218	0	2,746,643	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410014	0	862,340	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.560764		0			95.00	
200.00		Subtotal (see instructions)		0	25,584,547	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	25,584,547	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part V
Date/Time Prepared:
9/30/2020 9:21 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	410,590	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,006,205	0		54.00
60.00	06000	LABORATORY	1,001,787	0		60.00
65.00	06500	RESPIRATORY THERAPY	76,840	0		65.00
66.00	06600	PHYSICAL THERAPY	394,770	0		66.00
69.00	06900	ELECTROCARDIOLOGY	103,564	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	118,994	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	158,412	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,201	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	464,342	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	822,756	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	202,349	0		90.00
91.00	09100	EMERGENCY	1,044,323	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	353,571	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,168,704	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,168,704	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part I
Date/Time Prepared:
9/30/2020 9:21 am

			Title XIX		Hospital	Cost		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	270,689	50,468	220,221	1,872	117.64	30.00	
200.00	Total (lines 30 through 199)	270,689		220,221	1,872		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	167	19,646					30.00
200.00	Total (lines 30 through 199)	167	19,646					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part II
Date/Time Prepared:
9/30/2020 9:21 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)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	125,226	4,563,300	0.027442	100,492	2,758	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	135,665	19,546,642	0.006941	185,188	1,285	54.00
60.00	06000 LABORATORY	91,872	12,304,565	0.007466	169,261	1,264	60.00
65.00	06500 RESPIRATORY THERAPY	45,835	1,280,702	0.035789	159,933	5,724	65.00
66.00	06600 PHYSICAL THERAPY	37,608	3,393,912	0.011081	23,694	263	66.00
69.00	06900 ELECTROCARDIOLOGY	13,290	1,411,890	0.009413	6,245	59	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	12,749	254,000	0.050193	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	24,917	3,249,192	0.007669	44,001	337	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	877	52,914	0.016574	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	47,948	7,142,386	0.006713	286,673	1,924	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	86,742	1,435,865	0.060411	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	250,270	4,097,651	0.061076	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0.000000	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0.000000	0	0	88.02
90.00	09000 CLINIC	5,862	2,100	2.791429	0	0	90.00
91.00	09100 EMERGENCY	144,349	7,734,466	0.018663	51,382	959	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	51,409	1,810,993	0.028387	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,074,619	68,280,578		1,026,869	14,573	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1351		Period: From 03/01/2019 To 02/29/2020		Worksheet D Part III Date/Time Prepared: 9/30/2020 9:21 am		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	1,872	0.00	167			30.00	
200.00		Total (lines 30 through 199)	0	0	1,872		167			200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0							30.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		Title XIX		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1351		Period: From 03/01/2019 To 02/29/2020		Worksheet D Part IV Date/Time Prepared: 9/30/2020 9:21 am	
			Title XIX		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,563,300	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,546,642	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	12,304,565	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,280,702	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,393,912	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,411,890	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	254,000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,249,192	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	52,914	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,142,386	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,435,865	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,097,651	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
90.00	09000	CLINIC	0	0	0	2,100	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	7,734,466	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,810,993	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	68,280,578		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part IV
Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		Title XIX		Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	100,492	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	185,188	0	0	54.00
60.00	06000	LABORATORY	0.000000	169,261	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	159,933	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	23,694	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	6,245	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	44,001	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	286,673	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	51,382	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		1,026,869	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part V
Date/Time Prepared:
9/30/2020 9:21 am

			Title XIX		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.235865	0	846,359	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.124539	0	4,087,672	0	0	54.00
60.00	06000	LABORATORY	0.194126	0	2,190,741	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.605017	0	270,990	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.301675	0	288,467	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.141105	0	196,538	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.468480	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176064	0	146,434	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.375099	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.202535	0	665,745	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.609628	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1.266221				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	96.448571	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.380218	0	2,367,839	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.410014	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.560764	0	648,578			95.00
200.00		Subtotal (see instructions)		0	11,709,363	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	11,709,363	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet D
Part V
Date/Time Prepared:
9/30/2020 9:21 am

			Title XIX		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	199,626	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	509,075	0		54.00
60.00	06000	LABORATORY	425,280	0		60.00
65.00	06500	RESPIRATORY THERAPY	163,954	0		65.00
66.00	06600	PHYSICAL THERAPY	87,023	0		66.00
69.00	06900	ELECTROCARDIOLOGY	27,732	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,782	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	134,837	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	900,295	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	363,699			95.00
200.00		Subtotal (see instructions)	2,837,303	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,837,303	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 9:21 am

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,301	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,872	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,435	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	429	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	937	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)	429	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.98	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,909,779	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	728,944	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,180,835	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,180,835	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)	1,699.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,592,122	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,592,122	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		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)					912,619	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,504,741	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)					728,944	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					728,944	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)					437	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,699.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					742,533	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 9:21 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	270,689	3,909,779	0.069234	742,533	51,409
91.00	Nursing School cost	0	3,909,779	0.000000	742,533	0
92.00	Allied health cost	0	3,909,779	0.000000	742,533	0
93.00	All other Medical Education	0	3,909,779	0.000000	742,533	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet D-1 Date/Time Prepared: 9/30/2020 9:21 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,301 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,872 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,435 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			429 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			167 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			139.98 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			147.50 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,909,779 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			728,944 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,180,835 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,180,835 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)			1,699.17 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			283,761 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)			283,761 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital 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)						269,759	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						553,520	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						437	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,699.16	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						742,533	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet D-1

Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	270,689	3,909,779	0.069234	742,533	51,409	90.00
91.00	Nursing School cost	0	3,909,779	0.000000	742,533	0	91.00
92.00	Allied health cost	0	3,909,779	0.000000	742,533	0	92.00
93.00	All other Medical Education	0	3,909,779	0.000000	742,533	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet D-3 Date/Time Prepared: 9/30/2020 9:21 am	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,070,322		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.235865	291,517	68,759	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124539	264,868	32,986	54.00
60.00	06000 LABORATORY	0.194126	607,328	117,898	60.00
65.00	06500 RESPIRATORY THERAPY	0.605017	429,304	259,736	65.00
66.00	06600 PHYSICAL THERAPY	0.301675	110,788	33,422	66.00
69.00	06900 ELECTROCARDIOLOGY	0.141105	20,321	2,867	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.468480	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.176064	902,354	158,872	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.375099	12,350	4,632	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.202535	1,139,643	230,818	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.609628	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	96.448571	0	0	90.00
91.00	09100 EMERGENCY	0.380218	3,537	1,345	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.410014	3,132	1,284	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,785,142	912,619	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,785,142		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1351 Component CCN: 14-Z351	Period: From 03/01/2019 To 02/29/2020	Worksheet D-3 Date/Time Prepared: 9/30/2020 9:21 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.235865	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124539	9,548	1,189	54.00
60.00	06000 LABORATORY	0.194126	141,989	27,564	60.00
65.00	06500 RESPIRATORY THERAPY	0.605017	153,158	92,663	65.00
66.00	06600 PHYSICAL THERAPY	0.301675	220,479	66,513	66.00
69.00	06900 ELECTROCARDIOLOGY	0.141105	2,356	332	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.468480	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.176064	320,462	56,422	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.375099	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.202535	270,138	54,712	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.609628	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	96.448571	0	0	90.00
91.00	09100 EMERGENCY	0.380218	1,700	646	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.410014	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,119,830	300,041	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,119,830		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet D-3 Date/Time Prepared: 9/30/2020 9:21 am	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		633,162		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.235865	100,492	23,703	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.124539	185,188	23,063	54.00
60.00	06000 LABORATORY	0.194126	169,261	32,858	60.00
65.00	06500 RESPIRATORY THERAPY	0.605017	159,933	96,762	65.00
66.00	06600 PHYSICAL THERAPY	0.301675	23,694	7,148	66.00
69.00	06900 ELECTROCARDIOLOGY	0.141105	6,245	881	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.468480	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.176064	44,001	7,747	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.375099	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.202535	286,673	58,061	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.609628	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.266221	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000	0	0	88.02
90.00	09000 CLINIC	96.448571	0	0	90.00
91.00	09100 EMERGENCY	0.380218	51,382	19,536	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.410014	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,026,869	269,759	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)		1,026,869		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet E Part B Date/Time Prepared: 9/30/2020 9:21 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,168,704	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)		6,168,704	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		6,230,391	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)		44,668	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		4,064,973	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,120,750	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,120,750	30.00
31.00	Primary payer payments		1,481	31.00
32.00	Subtotal (line 30 minus line 31)		2,119,269	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)		893,480	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		580,762	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		687,301	36.00
37.00	Subtotal (see instructions)		2,700,031	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	ILLING ADJUSTMENT		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)		2,700,031	40.00
40.01	Sequestration adjustment (see instructions)		54,001	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		2,638,655	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)		7,375	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: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet E-1
Part I
Date/Time Prepared:
9/30/2020 9:21 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,188,996		2,711,263	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0	02/25/2020	72,608	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		-72,608	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,188,996		2,638,655	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		96,657		7,375	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,285,653		2,646,030	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1351

Period:

Worksheet E-1

Component CCN: 14-Z351

From 03/01/2019
To 02/29/2020Part I
Date/Time Prepared:
9/30/2020 9:21 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		787,943		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		787,943		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		230,044		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,017,987		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet E-1 Part II Date/Time Prepared: 9/30/2020 9:21 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: 14-1351

Period:

Worksheet E-2

Component CCN: 14-Z351

From 03/01/2019
To 02/29/2020Date/Time Prepared:
9/30/2020 9:21 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)		736,233	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)		303,041	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		429	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)		1,039,274	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,039,274	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)		1,039,274	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		512	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,038,762	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)		1,038,762	0	19.00
19.01	Sequestration adjustment (see instructions)		20,775	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		787,943	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)		230,044	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: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet E-3 Part V Date/Time Prepared: 9/30/2020 9:21 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,504,741 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,504,741 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,529,788 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,529,788 19.00
20.00	Deductibles (exclude professional component)			260,876 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,268,912 22.00
23.00	Coinsurance			5,797 23.00
24.00	Subtotal (line 22 minus line 23)			2,263,115 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			106,437 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			69,184 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			88,795 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,332,299 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			2,332,299 30.00
30.01	Sequestration adjustment (see instructions)			46,646 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
30.03	Sequestration adjustment-PARHM			0 30.03
31.00	Interim payments			2,188,996 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)			96,657 33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)			0 33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1351	Period: From 03/01/2019 To 02/29/2020	Worksheet E-3 Part VII Date/Time Prepared: 9/30/2020 9:21 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	553,520			1.00
2.00	Medical and other services			2,837,303	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	553,520		2,837,303	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	553,520		2,837,303	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	1,026,869		11,709,363	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,026,869		11,709,363	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	1,026,869		11,709,363	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	473,349		8,872,060	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	553,520		2,837,303	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	553,520		2,837,303	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	0		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	553,520		2,837,303	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	553,520		2,837,303	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	553,520		2,837,303	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	553,520		2,837,303	40.00
41.00	Interim payments	0		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	553,520		2,837,303	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

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

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet G

Date/Time Prepared:
9/30/2020 9:21 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	6,603,155	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	3,803,889	0	0	0	4.00
5.00 Other receivable	0	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	216,191	0	0	0	7.00
8.00 Prepaid expenses	540,299	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	11,163,534	0	0	0	11.00
FIXED ASSETS					
12.00 Land	135,111	0	0	0	12.00
13.00 Land improvements	351,668	0	0	0	13.00
14.00 Accumulated depreciation	-318,642	0	0	0	14.00
15.00 Buildings	13,489,865	0	0	0	15.00
16.00 Accumulated depreciation	-11,328,498	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	9,143,634	0	0	0	19.00
20.00 Accumulated depreciation	-7,577,389	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	0	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	1,573,806	0	0	0	27.00
28.00 Accumulated depreciation	-1,550,827	0	0	0	28.00
29.00 Minor equipment-nondepreciable	89,981	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	4,008,709	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	3,476,277	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	4,133,116	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	7,609,393	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	22,781,636	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,006,471	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,490,461	0	0	0	38.00
39.00 Payroll taxes payable	31,224	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	911,558	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	3,439,714	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	5,813,917	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	5,813,917	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	9,253,631	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	13,528,005	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	13,528,005	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	22,781,636	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet G-1

Date/Time Prepared:
9/30/2020 9:21 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		9,985,729		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,542,276				2.00
3.00	Total (sum of line 1 and line 2)		13,528,005		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)		13,528,005		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)		13,528,005		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: 14-1351

Period:
From 03/01/2019
To 02/29/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
9/30/2020 9:21 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,694,669		1,694,669	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	203,834		203,834	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,898,503		1,898,503	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)	1,898,503		1,898,503	17.00
18.00	Ancillary services	8,284,501	57,562,578	65,847,079	18.00
19.00	Outpatient services	0	2,100	2,100	19.00
20.00	RURAL HEALTH CLINIC	0	2,439,692	2,439,692	20.00
20.01	RURAL HEALTH CLINIC II	0	438,496	438,496	20.01
20.02	RURAL HEALTH CLINIC III	0	908,112	908,112	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	3,173,894	3,173,894	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,183,004	64,524,872	74,707,876	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,367,854		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)		26,367,854		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1351

Period:
From 03/01/2019
To 02/29/2020

Worksheet G-3

Date/Time Prepared:
9/30/2020 9:21 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,707,876	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,640,014	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,067,862	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,367,854	4.00
5.00	Net income from service to patients (line 3 minus line 4)	700,008	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	135,746	6.00
7.00	Income from investments	59,105	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	140,942	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	7,839	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	TAX REVENUE	210,200	24.00
24.01	RENTAL INCOME	71,136	24.01
24.02	MISCELLANEOUS INCOME	59,233	24.02
24.03	GRANT INCOME	371,775	24.03
24.04	EHR INCENTIVE	547,901	24.04
24.05	340B PROGRAM REVENUE	1,238,391	24.05
24.06	SALE OF EQUIPMENT	0	24.06
25.00	Total other income (sum of lines 6-24)	2,842,268	25.00
26.00	Total (line 5 plus line 25)	3,542,276	26.00
27.00	GAIN/(LOSS) ON DISPOSAL	0	27.00
27.01	LOSS ON INVESTMENTS	0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,542,276	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1351

Period:

Worksheet M-1

Component CCN: 14-3458

From 03/01/2019
To 02/29/2020Date/Time Prepared:
9/30/2020 9:21 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00 Physician	784,844	0	784,844	0	784,844	1.00
2.00 Physician Assistant	0	0	0	0	0	2.00
3.00 Nurse Practitioner	564,279	0	564,279	0	564,279	3.00
4.00 Visiting Nurse	0	0	0	0	0	4.00
5.00 Other Nurse	557,063	0	557,063	0	557,063	5.00
6.00 Clinical Psychologist	0	0	0	0	0	6.00
7.00 Clinical Social Worker	0	0	0	0	0	7.00
8.00 Laboratory Technician	0	0	0	0	0	8.00
9.00 Other Facility Health Care Staff Costs	47,374	0	47,374	0	47,374	9.00
10.00 Subtotal (sum of lines 1 through 9)	1,953,560	0	1,953,560	0	1,953,560	10.00
11.00 Physician Services Under Agreement	0	54,800	54,800	-37,800	17,000	11.00
12.00 Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00 Other Costs Under Agreement	0	178,123	178,123	0	178,123	13.00
14.00 Subtotal (sum of lines 11 through 13)	0	232,923	232,923	-37,800	195,123	14.00
15.00 Medical Supplies	0	19,075	19,075	0	19,075	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	2,423	2,423	0	2,423	18.00
19.00 Other Health Care Costs	0	106,458	106,458	0	106,458	19.00
20.00 Allowable GME Costs	0	0	0	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	127,956	127,956	0	127,956	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,953,560	360,879	2,314,439	-37,800	2,276,639	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	0	0	25.01
25.02 Chronic Care Management	0	0	0	0	0	25.02
26.00 All other nonreimbursable costs	0	0	0	0	0	26.00
27.00 Nonallowable GME costs	0	0	0	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00 Facility Costs	761,130	0	761,130	-123,017	638,113	29.00
30.00 Administrative Costs	0	0	0	0	0	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	761,130	0	761,130	-123,017	638,113	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	2,714,690	360,879	3,075,569	-160,817	2,914,752	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1351

Period:

Worksheet M-1

Component CCN: 14-3458

From 03/01/2019
To 02/29/2020Date/Time Prepared:
9/30/2020 9:21 am

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	784,844		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	564,279		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	557,063		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	47,374		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,953,560		10.00
11.00	Physician Services Under Agreement	0	17,000		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	178,123		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	195,123		14.00
15.00	Medical Supplies	0	19,075		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	2,423		18.00
19.00	Other Health Care Costs	0	106,458		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	127,956		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,276,639		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	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	638,113		29.00
30.00	Administrative Costs	0	0		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	638,113		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,914,752		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1351

Period:

Worksheet M-2

Component CCN: 14-3458

From 03/01/2019
To 02/29/2020

Date/Time Prepared:

9/30/2020 9:21 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.38	7,590	4,200	5,796		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.12	13,024	2,100	6,552		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.50	20,614		12,348	20,614	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.50	20,614			20,614	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)					2,276,639	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,276,639	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					638,113	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,273,779	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,911,892	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,911,892	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,911,892	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,188,531	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1351 Component CCN: 14-3458	Period: From 03/01/2019 To 02/29/2020	Worksheet M-3 Date/Time Prepared: 9/30/2020 9:21 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)			5,188,531	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			59,237	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,129,294	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			20,614	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			20,614	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			248.83	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		248.83	248.83	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	4,771	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,187,168	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	563	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	140,091	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	140,091	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1,327,259	16.00
16.01	Total program charges (see instructions)(from contractor's records)			967,136	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			12,883	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			17,680	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.)			971,499	16.04
16.05	Total program cost (see instructions)		0	989,179	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			95,205	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			171,810	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			989,179	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			34,874	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,024,053	22.00
23.00	Allowable bad debts (see instructions)			161,461	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			104,950	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			154,721	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			1,129,003	26.00
26.01	Sequestration adjustment (see instructions)			22,580	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,104,363	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)			2,060	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: 14-1351 Component CCN: 14-3458	Period: From 03/01/2019 To 02/29/2020	Worksheet M-4 Date/Time Prepared: 9/30/2020 9:21 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)		1,953,560	1,953,560	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000792	0.003134	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		1,547	6,122	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		12,691	5,632	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		14,238	11,754	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,276,639	2,276,639	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,911,892	2,911,892	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.006254	0.005163	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		18,211	15,034	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		32,449	26,788	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		89	352	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		364.60	76.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		61	166	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		22,241	12,633	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)			59,237	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)			34,874	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1351 Component CCN: 14-3458	Period: From 03/01/2019 To 02/29/2020	Worksheet M-5 Date/Time Prepared: 9/30/2020 9:21 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		1,049,969	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02		02/28/2020	54,394	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		02/28/2020	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)		54,394	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,104,363	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		2,060	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,106,423	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00