

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: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 10:54 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/25/2019	Time: 10:54 am
	2. ☐ Manually submitted 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 HSHS GOOD SHEPHERD HOSPITAL (14-0019) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 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) STEVEN UMLAND

Officer or Administrator of Provider(s)

CFO - HSHS CENTRAL ILLINOIS DIVISION

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-486,304	4,686	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		13,812		0	10.00
200.00	Total	0	-486,304	18,498	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0019		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:54 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 200 SOUTH CEDAR			PO Box:				1.00			
2.00	City: SHELBYVILLE			State: IL		Zip Code: 62565-1899		County: SHELBY 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		HSHS GOOD SHEPHERD HOSPITAL	140019	99914	1	07/01/1966	N	P	N	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		HSHS GOOD SHEPHERD HOSPITAL SWING BE	14U019	99914		04/13/1993	N	P	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		HSHS GOOD SHEPHERD HOSPITAL HHS	147622	99914		08/03/1995	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		HSHS GOOD SHEPHERD HOSPITAL RHC	143446	99914		06/05/1998	N	O	N	15.00
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)					07/01/2018		06/30/2019		20.00	
21.00	Type of Control (see instructions)					2				21.00	
						1.00		2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	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)				Y	Y				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: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/25/2019 10:54 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.	41	0	0	0	130	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		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.					07/01/2018	06/30/2019	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)					Y	Y	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.					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.					N		
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: 14-0019		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:54 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 §413.85? (see instructions)		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
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	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
From 07/01/2018
To 06/30/2019Worksheet 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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
						71.00
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
						75.00
						76.00

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				1.00				
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.06		
Rural Providers								
105.00	Does this hospital qualify as a CAH?			N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N	109.00
						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: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:54 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	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	17,508	0	120,216	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		148005	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0019		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 10:54 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: HOSPITAL SISTERS HEALTH SYSTEM		Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131				141.00	
142.00	Street: 4936 LAVERNA ROAD		PO Box:						142.00	
143.00	City: SPRINGFIELD		State: IL		Zip Code: 62707		143.00			
									1.00	
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
									1.00	
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.								N	146.00
									1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	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			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
									1.00	
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00
									1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	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)					07/01/2018	09/30/2018		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	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 10:54 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	09/26/2019	Y	09/26/2019
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: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/25/2019 10:54 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 10:54 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 10:54 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	30	10,950	0.00	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)		30	10,950	0.00	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)		30	10,950	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		30				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: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 10:54 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)	644	41	1,036			1.00
2.00 HMO and other (see instructions)	0	130				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	293	0	293			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	56			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	937	41	1,385			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)	937	41	1,385	0.00	116.57	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	2,920	0	3,822	0.00	8.19	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	1,718	719	7,693	0.00	8.92	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	133.68	27.00
28.00 Observation Bed Days		51	363			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 10:54 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	240	15	371	1.00
2.00 HMO and other (see instructions)			0	47		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	240	15	371	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/25/2019 10:54 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	5,242,075	0	5,242,075	232,886.69	22.51
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		100,577	0	100,577	2,080.00	48.35
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		52,416	0	52,416	1,400.00	37.44
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		285,916	23,837	309,753	12,770.67	24.26
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,856,288	0	1,856,288	21,902.80	84.75
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		368,488	0	368,488	3,114.40	118.32
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		268,994	0	268,994	3,743.31	71.86
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,032,293	0	1,032,293		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		63,699	0	63,699		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		15,466	0	15,466		
24.00	Wage-related costs (RHC/FQHC)		8,858	0	8,858		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		63,567	0	63,567		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	638,245	0	638,245	38,108.62	16.75

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/25/2019 10:54 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		69,300	0	69,300	425.43	162.89	28.00
29.00	Maintenance & Repairs	6.00	252,548	0	252,548	10,546.50	23.95	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	202,149	-23,837	178,312	15,706.51	11.35	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	173,643	-130,885	42,758	3,200.65	13.36	34.00
35.00	Dietary under contract (see instructions)		41,072	0	41,072	757.25	54.24	35.00
36.00	Cafeteria	11.00	0	130,885	130,885	9,818.75	13.33	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	180,951	0	180,951	4,811.50	37.61	38.00
39.00	Central Services and Supply	14.00	98,112	0	98,112	6,501.69	15.09	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	206,077	0	206,077	11,914.96	17.30	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/25/2019 10:54 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	5,199,454	0	5,199,454	230,589.37	22.55	1.00
2.00	Excluded area salaries (see instructions)	285,916	23,837	309,753	12,770.67	24.26	2.00
3.00	Subtotal salaries (line 1 minus line 2)	4,913,538	-23,837	4,889,701	217,818.70	22.45	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,493,770	0	2,493,770	28,760.51	86.71	4.00
5.00	Subtotal wage-related costs (see inst.)	1,095,860	0	1,095,860	0.00	22.41	5.00
6.00	Total (sum of lines 3 thru 5)	8,503,168	-23,837	8,479,331	246,579.21	34.39	6.00
7.00	Total overhead cost (see instructions)	1,862,097	-23,837	1,838,260	101,791.86	18.06	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/25/2019 10:54 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		118,195	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		586,811	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		5,044	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		10,297	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,050	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		309,092	17.00
18.00	Medicare Taxes - Employers Portion Only		76,010	18.00
19.00	Unemployment Insurance		13,817	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		1,120,316	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,856,288	1,120,316	1.00
2.00	Hospital	1,856,288	1,120,316	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0019 Component CCN: 14-7622		Period: From 07/01/2018 To 06/30/2019		Worksheet S-4 Date/Time Prepared: 11/25/2019 10:54 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	3,932	0	352	4,284	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	173.00	7.00	54.00	234.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		1.20	0.00	1.20	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.26	0.00	0.26	5.00
6.00	Direct Nursing Service			5.93	0.00	5.93	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.09	0.00	0.09	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.28	0.00	0.28	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.06	0.00	0.06	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.28	0.00	0.28	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	TECH			0.10	0.00	0.10	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	983	143	56	15	1,197	21.00
22.00	Skilled Nursing Visit Charges	175,317	25,488	10,012	2,696	213,513	22.00
23.00	Physical Therapy Visits	1,048	62	18	4	1,132	23.00
24.00	Physical Therapy Visit Charges	204,185	12,108	0	783	217,076	24.00
25.00	Occupational Therapy Visits	397	46	3	2	448	25.00
26.00	Occupational Therapy Visit Charges	91,447	10,638	694	463	103,242	26.00
27.00	Speech Pathology Visits	40	3	1	0	44	27.00
28.00	Speech Pathology Visit Charges	8,652	653	218	0	9,523	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	51	48	0	0	99	31.00
32.00	Home Health Aide Visit Charges	4,732	4,353	0	0	9,085	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,519	302	78	21	2,920	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	484,333	53,240	10,924	3,942	552,439	35.00
36.00	Total Number of Episodes (standard/non outlier)	163		27	2	192	36.00
37.00	Total Number of Outlier Episodes		8		0	8	37.00
38.00	Total Non-Routine Medical Supply Charges	3,996	0	352	441	4,789	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-7

Date/Time Prepared:
11/25/2019 10:54 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/13/1993		2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	0	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	0	0	12.00
13.00		RUB	0	0	13.00
14.00		RUA	0	0	14.00
15.00		RVC	0	0	15.00
16.00		RVB	0	0	16.00
17.00		RVA	0	17	17.00
18.00		RHC	0	10	18.00
19.00		RHB	0	0	19.00
20.00		RHA	0	24	20.00
21.00		RMC	0	0	21.00
22.00		RMB	0	0	22.00
23.00		RMA	0	11	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	0	9	28.00
29.00		HE2	0	0	29.00
30.00		HE1	0	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	0	18	32.00
33.00		HC2	0	3	33.00
34.00		HC1	0	11	34.00
35.00		HB2	0	0	35.00
36.00		HB1	0	55	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	0	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	0	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	0	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	0	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	0	5	50.00
51.00		CB2	0	2	51.00
52.00		CB1	0	12	52.00
53.00		CA2	0	0	53.00
54.00		CA1	0	98	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-7

Date/Time Prepared:
11/25/2019 10:54 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	12	12	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	6	6	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	293	293	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0019 Component CCN: 14-3446		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/25/2019 10:54 am		
				RHC I		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				200 SOUTH CEDAR STREET				1.00	
				City	State	ZIP Code				
				1.00	2.00	3.00				
2.00	City, State, ZIP Code, County				SHELBYVILLE IL 62565				2.00	
				1.00						
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00	
				Grant Award		Date				
				1.00		2.00				
Source of Federal Funds										
4.00	Community Health Center (Section 330(d), PHS Act)								4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00	
7.00	Appalachian Regional Commission								7.00	
8.00	Look-Alikes								8.00	
9.00	OTHER (SPECIFY)								9.00	
				1.00		2.00				
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00	
				Sunday		Monday		Tuesday		
				from	to	from	to	from		
				1.00	2.00	3.00	4.00	5.00		
Facility hours of operations (1)										
11.00	CLINIC				08:00		19:00		11.00	
				1.00		2.00				
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00	
				Provider name		CCN number				
				1.00		2.00				
14.00	RHC/FQHC name, CCN number								14.00	
				Y/N	V	XVIII	XIX	Total Visits		
				1.00	2.00	3.00	4.00	5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00	
				County						
				4.00						
2.00	City, State, ZIP Code, County				SHELBY				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				19:00	08:00	19:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0019 Component CCN: 14-3446	Period: From 07/01/2018 To 06/30/2019	Worksheet S-8 Date/Time Prepared: 11/25/2019 10:54 am	
			RHC I		Cost	
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC	08:00	17:00			11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-10

Date/Time Prepared:
11/25/2019 10:54 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)		0.374466	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		161,382	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			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		992,896	6.00
7.00	Medicaid cost (line 1 times line 6)		371,806	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)		210,424	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		210,424	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)	261,972	698	262,670
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	98,100	698	98,798
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	98,100	698	98,798
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,086,683	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		77,090	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		118,600	27.01
28.00	Non-Medicare bad debt expense (see instructions)		968,083	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		404,024	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		502,822	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		713,246	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
11/25/2019 10:54 am

	Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification s (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		717,847	717,847	-208,184	509,663	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	511,434	511,434	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,226,438	1,226,438	0	1,226,438	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	638,245	2,418,547	3,056,792	-61,072	2,995,720	5.00
6.00	00600	MAINTENANCE & REPAIRS	252,548	195,797	448,345	-97	448,248	6.00
7.00	00700	OPERATION OF PLANT	0	294,064	294,064	-58,253	235,811	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,692	50,692	0	50,692	8.00
9.00	00900	HOUSEKEEPING	202,149	12,790	214,939	-23,837	191,102	9.00
10.00	01000	DIETARY	173,643	235,414	409,057	-308,330	100,727	10.00
11.00	01100	CAFETERIA	0	0	0	308,330	308,330	11.00
13.00	01300	NURSING ADMINISTRATION	180,951	208,173	389,124	0	389,124	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	98,112	6,079	104,191	0	104,191	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206,077	15,627	221,704	0	221,704	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	674,212	407,950	1,082,162	-2,557	1,079,605	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	46,722	292,327	339,049	-140,948	198,101	50.00
53.00	05300	ANESTHESIOLOGY	0	3,510	3,510	74,138	77,648	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	432,897	262,636	695,533	0	695,533	54.00
60.00	06000	LABORATORY	391,389	565,420	956,809	-19,405	937,404	60.00
65.00	06500	RESPIRATORY THERAPY	227,286	74,090	301,376	-1,673	299,703	65.00
66.00	06600	PHYSICAL THERAPY	240,920	394,277	635,197	-729	634,468	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	34,116	34,116	5	34,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164,461	553,793	718,254	-10,448	707,806	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	30,287	1,400	31,687	0	31,687	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	170,959	988,237	1,159,196	-3,801	1,155,395	88.00
90.00	09000	CLINIC	142,227	7,732	149,959	-5	149,954	90.00
91.00	09100	EMERGENCY	563,595	1,203,627	1,767,222	0	1,767,222	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	119,479	78,765	198,244	-6,040	192,204	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	286,142	180,583	466,725	-2,157	464,568	101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		144,063	144,063	-144,063	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,242,301	10,573,994	15,816,295	-97,692	15,718,603	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	-226	484,134	483,908	97,692	581,600	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	5,242,075	11,058,128	16,300,203	0	16,300,203	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet A
Date/Time Prepared:
11/25/2019 10:54 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	-144,063	365,600	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	511,434	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-188,726	1,037,712	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-410,435	2,585,285	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	448,248	6.00
7.00	00700	OPERATION OF PLANT	0	235,811	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,692	8.00
9.00	00900	HOUSEKEEPING	0	191,102	9.00
10.00	01000	DIETARY	-287	100,440	10.00
11.00	01100	CAFETERIA	-52,307	256,023	11.00
13.00	01300	NURSING ADMINISTRATION	-2,188	386,936	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-132	104,059	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,379	219,325	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-48,479	1,031,126	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-5,850	192,251	50.00
53.00	05300	ANESTHESIOLOGY	0	77,648	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-560	694,973	54.00
60.00	06000	LABORATORY	-1,056	936,348	60.00
65.00	06500	RESPIRATORY THERAPY	-563	299,140	65.00
66.00	06600	PHYSICAL THERAPY	-696	633,772	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	34,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-134	707,672	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	-14,619	17,068	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	128,058	1,283,453	88.00
90.00	09000	CLINIC	-3,715	146,239	90.00
91.00	09100	EMERGENCY	-731,723	1,035,499	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-27	192,177	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	-835	463,733	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,480,716	14,237,887	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	581,600	192.00
194.00	07950	FARM EXPENSES	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,480,716	14,819,487	200.00

RECLASSIFICATIONS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
11/25/2019 10:54 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - MEDICAL CENTER RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	23,837	0		1.00
	0		23,837	0		
	C - TELEPHONE EXPENSE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,460		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	7,460		
	E - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	164,021		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	0		0	164,021		
	F - MEDICAL CENTER UTILITLES RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	58,253		1.00
	0		0	58,253		
	G - PHYSICIAN BUILDING DEPR RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,602		1.00
2.00		0.00	0	0		2.00
	0		0	15,602		
	H - DEPRECIATION EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	342,486		1.00
	0		0	342,486		
	J - CAFETERIA EXPENSE RECLASS					
1.00	CAFETERIA	11.00	130,885	177,445		1.00
	0		130,885	177,445		
	K - REAL ESTATE TAX RECLASS					
1.00	OTHER CAP REL COSTS	3.00	0	10,768		1.00
	TOTALS		0	10,768		
	M - INTEREST EXPENSE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	144,063		1.00
	0		0	144,063		
	N - MEDICAL SUPPLIES RECLAS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5		1.00
	0		0	5		
	P - DR PAINTER PURCHASED SERVICE					
1.00	ANESTHESIOLOGY	53.00	0	74,138		1.00
	TOTALS		0	74,138		
500.00	Grand Total: Increases		154,722	994,241		500.00

RECLASSIFICATIONS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
11/25/2019 10:54 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - MEDICAL CENTER RECLASS						
1.00	HOUSEKEEPING	9.00	23,837	0	0		1.00
	0		23,837	0			
	C - TELEPHONE EXPENSE RECLASS						
1.00	PHYSICAL THERAPY	66.00	0	729	0		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	793	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	3,771	0		3.00
4.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	10	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	2,157	0		5.00
	0		0	7,460			
	E - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	57,764	10		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	97	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,557	0		3.00
4.00	OPERATING ROOM	50.00	0	66,810	0		4.00
5.00	LABORATORY	60.00	0	19,405	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	1,673	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,655	0		7.00
8.00	RURAL HEALTH CLINIC	88.00	0	30	0		8.00
9.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	6,030	0		9.00
	0		0	164,021			
	F - MEDICAL CENTER UTILITIES RECLASS						
1.00	OPERATION OF PLANT	7.00	0	58,253	0		1.00
	0		0	58,253			
	G - PHYSICIAN BUILDING DEPR RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,215	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	387	9		2.00
	0		0	15,602			
	H - DEPRECIATION EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	342,486	9		1.00
	0		0	342,486			
	J - CAFETERIA EXPENSE RECLASS						
1.00	DIETARY	10.00	130,885	177,445	0		1.00
	0		130,885	177,445			
	K - REAL ESTATE TAX RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,768	6		1.00
	TOTALS		0	10,768			
	M - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	144,063	11		1.00
	0		0	144,063			
	N - MEDICAL SUPPLIES RECLAS						
1.00	CLINIC	90.00	0	5	0		1.00
	0		0	5			
	P - DR PAINTER PURCHASED SERVICE						
1.00	OPERATING ROOM	50.00	0	74,138	0		1.00
	TOTALS		0	74,138			
500.00	Grand Total: Decreases		154,722	994,241			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/25/2019 10:54 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	617,631	0	0	0	0	1.00	
2.00	Land Improvements	282,931	0	0	0	0	2.00	
3.00	Buildings and Fixtures	13,715,128	1,751,146	0	1,751,146	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	4,498,311	336,792	0	336,792	0	5.00	
6.00	Movable Equipment	10,476,703	633,607	0	633,607	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	29,590,704	2,721,545	0	2,721,545	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	29,590,704	2,721,545	0	2,721,545	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	617,631	0				1.00	
2.00	Land Improvements	282,931	0				2.00	
3.00	Buildings and Fixtures	15,466,274	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	4,835,103	0				5.00	
6.00	Movable Equipment	11,110,310	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	32,312,249	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	32,312,249	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/25/2019 10:54 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	715,304	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	715,304	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	2,543	717,847				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	2,543	717,847				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,366,836	0	16,366,836	0.506521	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,945,413	0	15,945,413	0.493479	0	2.00
3.00	Total (sum of lines 1-2)	32,312,249	0	32,312,249	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	5,454	0	5,454	357,603	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,314	0	5,314	342,099	164,021	2.00
3.00	Total (sum of lines 1-2)	10,768	0	10,768	699,702	164,021	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	0	5,454	2,543	365,600	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,314	0	511,434	2.00
3.00	Total (sum of lines 1-2)	0	0	10,768	2,543	877,034	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-144,063	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-5,800	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	-782,767			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	315,144			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-52,307	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,960	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SELF INSURANCE EXPENSE	A	-184,814	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/25/2019 10:54 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
Cost Center Description	Basis/Code (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00			
33.01 MISCELLANEOUS INCOME	B	-4,935	ADMINISTRATIVE & GENERAL		5.00	0	33.01
33.02 PROMOTIONAL ITEMS	A	-78,618	ADMINISTRATIVE & GENERAL		5.00	0	33.02
33.03 SWITCHBOARD SALARY EXPENSE	A	-1,997	ADMINISTRATIVE & GENERAL		5.00	0	33.03
33.04 SWITCHBOARD BENEFIT EXPENSE	A	-125	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.04
33.05 PATIENT TELEPHONES	A	-3,705	ADMINISTRATIVE & GENERAL		5.00	0	33.05
33.06 LOBBYING DUES	A	-8,283	ADMINISTRATIVE & GENERAL		5.00	0	33.06
33.07 FRA TAX	A	-481,963	ADMINISTRATIVE & GENERAL		5.00	0	33.07
33.08 WELLNESS FOR LIFE REVENUE	B	-14,619	CARDIAC REHABILITATION		76.97	0	33.08
33.09 FOUNDATION AND FUNDRAISING EXPENSES	A	7,516	ADMINISTRATIVE & GENERAL		5.00	0	33.09
33.10 DONATIONS	A	-300	ADMINISTRATIVE & GENERAL		5.00	0	33.10
33.11 REAL ESTATE TAXES	A	-10,768	ADMINISTRATIVE & GENERAL		5.00	0	33.11
33.12 NON-PATIENT TRAVEL EXPENSE	A	-3,787	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	33.12
33.13 NON-PATIENT TRAVEL EXPENSE	A	-7,571	ADMINISTRATIVE & GENERAL		5.00	0	33.13
33.14 NON-PATIENT TRAVEL EXPENSE	A	-287	DIETARY		10.00	0	33.14
33.15 NON-PATIENT TRAVEL EXPENSE	A	-2,188	NURSING ADMINISTRATION		13.00	0	33.15
33.16 NON-PATIENT TRAVEL EXPENSE	A	-132	CENTRAL SERVICES & SUPPLY		14.00	0	33.16
33.17 NON-PATIENT TRAVEL EXPENSE	A	-419	MEDICAL RECORDS & LIBRARY		16.00	0	33.17
33.18 NON-PATIENT TRAVEL EXPENSE	A	-479	ADULTS & PEDIATRICS		30.00	0	33.18
33.19 NON-PATIENT TRAVEL EXPENSE	A	-5,850	OPERATING ROOM		50.00	0	33.19
33.20 NON-PATIENT TRAVEL EXPENSE	A	-560	RADIOLOGY-DIAGNOSTIC		54.00	0	33.20
33.21 NON-PATIENT TRAVEL EXPENSE	A	-1,056	LABORATORY		60.00	0	33.21
33.22 NON-PATIENT TRAVEL EXPENSE	A	-563	RESPIRATORY THERAPY		65.00	0	33.22
33.23 NON-PATIENT TRAVEL EXPENSE	A	-696	PHYSICAL THERAPY		66.00	0	33.23
33.24 NON-PATIENT TRAVEL EXPENSE	A	-134	DRUGS CHARGED TO PATIENTS		73.00	0	33.24
33.25 NON-PATIENT TRAVEL EXPENSE	A	-1,097	RURAL HEALTH CLINIC		88.00	0	33.25
33.26 NON-PATIENT TRAVEL EXPENSE	A	-244	CLINIC		90.00	0	33.26
33.27 NON-PATIENT TRAVEL EXPENSE	A	-427	EMERGENCY		91.00	0	33.27
33.28 NON-PATIENT TRAVEL EXPENSE	A	-27	DURABLE MEDICAL EQUIP-RENTED		96.00	0	33.28
33.29 NON-PATIENT TRAVEL EXPENSE	A	-835	HOME HEALTH AGENCY		101.00	0	33.29
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,480,716					50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
11/25/2019 10:54 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC/SS	421,141	235,152	1.00
2.00	88.00	RURAL HEALTH CLINIC	HSHS MEDICAL GROUP	129,155	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HSHS RELATED PARTY ACTIVITY	641,967	641,967	3.00
4.00	8.00	LAUNDRY & LINEN SERVICE	HSHS RELATED PARTY ACTIVITY	49,244	49,244	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,241,507	926,363	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	HSHS	100.00	HSHS	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-1

Date/Time Prepared:
11/25/2019 10:54 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	185,989	0		1.00
2.00	129,155	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	315,144			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-2

Date/Time Prepared:
11/25/2019 10:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	48,000	48,000	0	0	0	1.00
2.00	90.00	CLINIC	3,471	3,471	0	0	0	2.00
3.00	91.00	EMERGENCY	1,047,936	679,448	368,488	211,500	3,114	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,099,407	730,919	368,488		3,114	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	90.00	CLINIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	316,640	15,832	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			316,640	15,832	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	48,000		1.00
2.00	90.00	CLINIC	0	0	0	3,471		2.00
3.00	91.00	EMERGENCY	0	316,640	51,848	731,296		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	316,640	51,848	782,767		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	365,600	365,600			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	511,434		511,434		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,037,712	4,139	5,790	1,047,641	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,585,285	43,794	61,263	127,555	5.00
6.00	00600	MAINTENANCE & REPAIRS	448,248	8,804	12,316	50,472	6.00
7.00	00700	OPERATION OF PLANT	235,811	8,470	11,849	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	50,692	7,400	10,351	0	8.00
9.00	00900	HOUSEKEEPING	191,102	3,516	4,918	35,636	9.00
10.00	01000	DIETARY	100,440	11,200	15,668	8,545	10.00
11.00	01100	CAFETERIA	256,023	3,928	5,495	26,158	11.00
13.00	01300	NURSING ADMINISTRATION	386,936	3,378	4,726	36,163	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	104,059	19,209	26,871	19,608	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219,325	8,632	12,075	41,185	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,031,126	52,882	73,980	134,745	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	192,251	29,997	41,962	9,337	50.00
53.00	05300	ANESTHESIOLOGY	77,648	589	824	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,973	25,921	36,261	86,515	54.00
60.00	06000	LABORATORY	936,348	10,248	14,335	78,220	60.00
65.00	06500	RESPIRATORY THERAPY	299,140	7,228	10,111	45,424	65.00
66.00	06600	PHYSICAL THERAPY	633,772	18,929	26,479	48,148	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,121	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	707,672	3,879	5,426	32,868	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	17,068	7,012	9,809	6,053	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,283,453	23,648	33,080	34,166	88.00
90.00	09000	CLINIC	146,239	37,995	53,151	28,424	90.00
91.00	09100	EMERGENCY	1,035,499	9,840	13,765	112,636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	192,177	8,760	12,254	23,878	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	463,733	6,202	8,675	57,186	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,237,887	365,600	511,434	1,042,922	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	581,600	0	0	4,719	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	194.00
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)	14,819,487	365,600	511,434	1,047,641	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,817,897					5.00
6.00	00600	MAINTENANCE & REPAIRS	122,055	641,895				6.00
7.00	00700	OPERATION OF PLANT	60,138	17,603	333,871			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,070	15,378	8,224	108,115		8.00
9.00	00900	HOUSEKEEPING	55,217	7,307	3,908	0	301,604	9.00
10.00	01000	DIETARY	31,897	23,277	12,448	0	11,669	10.00
11.00	01100	CAFETERIA	68,467	8,164	4,366	0	4,093	11.00
13.00	01300	NURSING ADMINISTRATION	101,244	7,021	3,755	0	3,520	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,856	39,921	21,350	733	20,013	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,028	17,940	9,594	0	8,994	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	303,526	109,903	58,776	41,314	55,098	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	64,227	62,340	33,340	1,629	31,253	50.00
53.00	05300	ANESTHESIOLOGY	18,563	1,225	655	0	614	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	198,089	53,871	28,810	18,028	27,007	54.00
60.00	06000	LABORATORY	243,986	21,297	11,390	0	10,677	60.00
65.00	06500	RESPIRATORY THERAPY	84,973	15,021	8,033	0	7,531	65.00
66.00	06600	PHYSICAL THERAPY	170,772	39,339	21,039	9,750	19,722	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,011	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	176,059	8,062	4,311	0	4,042	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	9,378	14,572	7,793	0	7,306	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	322,685	49,146	26,283	531	24,638	88.00
90.00	09000	CLINIC	62,410	78,964	42,230	402	39,587	90.00
91.00	09100	EMERGENCY	275,118	20,450	10,937	35,728	10,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	55,662	18,205	9,736	0	9,127	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	125,802	12,889	6,893	0	6,461	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,680,233	641,895	333,871	108,115	301,604	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	137,664	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
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)	2,817,897	641,895	333,871	108,115	301,604	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	215,144					10.00
11.00	01100	CAFETERIA	0	376,694				11.00
13.00	01300	NURSING ADMINISTRATION	0	10,302	557,045			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,673	0	305,293		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,188	0	267	409,228	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	215,144	60,904	290,426	6,397	115,663	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,186	15,193	8,412	22,974	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	40,675	0	12,959	45,990	54.00
60.00	06000	LABORATORY	0	37,783	0	89,221	45,990	60.00
65.00	06500	RESPIRATORY THERAPY	0	30,825	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	17,632	0	2,340	34,503	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,960	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	8,582	0	147,217	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,281	0	315	22,974	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	7,309	34,852	3,065	86,631	88.00
90.00	09000	CLINIC	0	13,473	64,246	524	0	90.00
91.00	09100	EMERGENCY	0	31,945	152,328	10,645	34,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	31,800	0	913	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	35,767	0	2,058	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	215,144	372,325	557,045	305,293	409,228	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	4,369	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
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)	215,144	376,694	557,045	305,293	409,228	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,549,884	0	2,549,884	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	516,101	0	516,101	50.00
53.00	05300	ANESTHESIOLOGY	0	100,118	0	100,118	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,269,099	0	1,269,099	54.00
60.00	06000	LABORATORY	0	1,499,495	0	1,499,495	60.00
65.00	06500	RESPIRATORY THERAPY	0	508,286	0	508,286	65.00
66.00	06600	PHYSICAL THERAPY	0	1,042,425	0	1,042,425	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	63,092	0	63,092	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,098,118	0	1,098,118	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	105,561	0	105,561	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,929,487	0	1,929,487	88.00
90.00	09000	CLINIC	0	567,645	0	567,645	90.00
91.00	09100	EMERGENCY	0	1,753,646	0	1,753,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	362,512	0	362,512	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	725,666	0	725,666	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,091,135	0	14,091,135	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	728,352	0	728,352	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	14,819,487	0	14,819,487	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,139	5,790	9,929	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,999	43,794	61,263	116,056	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	8,804	12,316	21,120	6.00
7.00	00700	OPERATION OF PLANT	0	8,470	11,849	20,319	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,400	10,351	17,751	8.00
9.00	00900	HOUSEKEEPING	0	3,516	4,918	8,434	9.00
10.00	01000	DIETARY	0	11,200	15,668	26,868	10.00
11.00	01100	CAFETERIA	0	3,928	5,495	9,423	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,378	4,726	8,104	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,209	26,871	46,080	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,632	12,075	20,707	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	52,882	73,980	126,862	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	29,997	41,962	71,959	50.00
53.00	05300	ANESTHESIOLOGY	0	589	824	1,413	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,921	36,261	62,182	54.00
60.00	06000	LABORATORY	0	10,248	14,335	24,583	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,228	10,111	17,339	65.00
66.00	06600	PHYSICAL THERAPY	0	18,929	26,479	45,408	66.00
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	3,879	5,426	9,305	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,012	9,809	16,821	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	23,648	33,080	56,728	88.00
90.00	09000	CLINIC	0	37,995	53,151	91,146	90.00
91.00	09100	EMERGENCY	0	9,840	13,765	23,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	8,760	12,254	21,014	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	6,202	8,675	14,877	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,999	365,600	511,434	888,033	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,999	365,600	511,434	888,033	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	117,265					5.00
6.00	00600	MAINTENANCE & REPAIRS	5,079	26,677				6.00
7.00	00700	OPERATION OF PLANT	2,503	732	23,554			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	669	639	580	19,639		8.00
9.00	00900	HOUSEKEEPING	2,298	304	276	0	11,650	9.00
10.00	01000	DIETARY	1,327	967	878	0	451	10.00
11.00	01100	CAFETERIA	2,849	339	308	0	158	11.00
13.00	01300	NURSING ADMINISTRATION	4,213	292	265	0	136	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,659	1,659	1,506	133	773	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,748	746	677	0	347	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,631	4,566	4,147	7,505	2,128	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,673	2,591	2,352	296	1,207	50.00
53.00	05300	ANESTHESIOLOGY	773	51	46	0	24	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,243	2,239	2,032	3,275	1,043	54.00
60.00	06000	LABORATORY	10,154	885	804	0	412	60.00
65.00	06500	RESPIRATORY THERAPY	3,536	624	567	0	291	65.00
66.00	06600	PHYSICAL THERAPY	7,107	1,635	1,484	1,771	762	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	333	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	7,327	335	304	0	156	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	390	606	550	0	282	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	13,427	2,042	1,854	96	952	88.00
90.00	09000	CLINIC	2,597	3,282	2,979	73	1,529	90.00
91.00	09100	EMERGENCY	11,449	850	772	6,490	396	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	2,316	757	687	0	353	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	5,235	536	486	0	250	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,536	26,677	23,554	19,639	11,650	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,729	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
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)	117,265	26,677	23,554	19,639	11,650	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	30,572					10.00
11.00	01100	CAFETERIA	0	13,325				11.00
13.00	01300	NURSING ADMINISTRATION	0	364	13,717			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	484	0	52,480		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	891	0	46	26,552	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,572	2,152	7,152	1,100	7,503	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	113	374	1,446	1,491	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,439	0	2,228	2,984	54.00
60.00	06000	LABORATORY	0	1,337	0	15,337	2,984	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,090	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	624	0	402	2,239	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,603	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	304	0	25,306	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	116	0	54	1,491	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	259	858	527	5,621	88.00
90.00	09000	CLINIC	0	477	1,582	90	0	90.00
91.00	09100	EMERGENCY	0	1,130	3,751	1,830	2,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	1,125	0	157	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	1,265	0	354	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,572	13,170	13,717	52,480	26,552	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	155	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
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)	30,572	13,325	13,717	52,480	26,552	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		207,598	0	207,598	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		84,590	0	84,590	50.00
53.00	05300	ANESTHESIOLOGY		2,307	0	2,307	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		86,485	0	86,485	54.00
60.00	06000	LABORATORY		57,237	0	57,237	60.00
65.00	06500	RESPIRATORY THERAPY		23,877	0	23,877	65.00
66.00	06600	PHYSICAL THERAPY		61,888	0	61,888	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		3,936	0	3,936	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		43,348	0	43,348	73.00
76.00	03950	OTHER ANCILLARY COSTS		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		20,367	0	20,367	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		82,688	0	82,688	88.00
90.00	09000	CLINIC		104,024	0	104,024	90.00
91.00	09100	EMERGENCY		53,579	0	53,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		26,635	0	26,635	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY		23,545	0	23,545	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	882,104	0	882,104	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		5,929	0	5,929	192.00
194.00	07950	FARM EXPENSES		0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	888,033	0	888,033	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	74,457					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,457				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	843	843	5,242,075			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,919	8,919	638,245	-2,817,897	12,001,590	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,793	1,793	252,548	0	519,840	6.00
7.00	00700	OPERATION OF PLANT	1,725	1,725	0	0	256,130	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	0	0	68,443	8.00
9.00	00900	HOUSEKEEPING	716	716	178,312	0	235,172	9.00
10.00	01000	DIETARY	2,281	2,281	42,758	0	135,853	10.00
11.00	01100	CAFETERIA	800	800	130,885	0	291,604	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	180,951	0	431,203	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	98,112	0	169,747	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	206,077	0	281,217	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	674,212	0	1,292,733	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,109	6,109	46,722	0	273,547	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	0	79,061	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	432,897	0	843,670	54.00
60.00	06000	LABORATORY	2,087	2,087	391,389	0	1,039,151	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	227,286	0	361,903	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	240,920	0	727,328	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	34,121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	164,461	0	749,845	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	30,287	0	39,942	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	170,959	0	1,374,347	88.00
90.00	09000	CLINIC	7,738	7,738	142,227	0	265,809	90.00
91.00	09100	EMERGENCY	2,004	2,004	563,595	0	1,171,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	119,479	0	237,069	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	286,142	0	535,796	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,457	74,457	5,218,464	-2,817,897	11,415,271	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	23,611	0	586,319	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
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)	365,600	511,434	1,047,641		2,817,897	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.910217	6.868850	0.199852		0.234794	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,929		117,265	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001894		0.009771	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: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	62,902					6.00
7.00	00700	OPERATION OF PLANT	1,725	61,177				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	60,446			8.00
9.00	00900	HOUSEKEEPING	716	716	0	58,954		9.00
10.00	01000	DIETARY	2,281	2,281	0	2,281	7,110	10.00
11.00	01100	CAFETERIA	800	800	0	800	0	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	0	688	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	410	3,912	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	0	1,758	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	23,098	10,770	7,110	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,109	6,109	911	6,109	0	50.00
53.00	05300	ANESTHESIOLOGY	120	120	0	120	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	10,079	5,279	0	54.00
60.00	06000	LABORATORY	2,087	2,087	0	2,087	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	0	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	5,451	3,855	0	66.00
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	790	790	0	790	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	0	1,428	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	297	4,816	0	88.00
90.00	09000	CLINIC	7,738	7,738	225	7,738	0	90.00
91.00	09100	EMERGENCY	2,004	2,004	19,975	2,004	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	0	1,784	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	0	1,263	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	62,902	61,177	60,446	58,954	7,110	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
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
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)	641,895	333,871	108,115	301,604	215,144	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.204683	5.457460	1.788621	5.115921	30.259353	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	26,677	23,554	19,639	11,650	30,572	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.424104	0.385014	0.324902	0.197612	4.299859	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: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description			CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	14.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	179,357					11.00
13.00	01300	NURSING ADMINISTRATION	4,905	55,621				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,510	0	1,083,600			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,993	0	947	9,868		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	28,999	28,999	22,706	2,789	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,517	1,517	29,856	554	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,367	0	45,997	1,109	0	54.00
60.00	06000	LABORATORY	17,990	0	316,679	1,109	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,677	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	8,395	0	8,304	832	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	74,395	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	4,086	0	522,531	0	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,562	0	1,119	554	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,480	3,480	10,878	2,089	0	88.00
90.00	09000	CLINIC	6,415	6,415	1,860	0	0	90.00
91.00	09100	EMERGENCY	15,210	15,210	37,784	832	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	15,141	0	3,241	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	17,030	0	7,303	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	177,277	55,621	1,083,600	9,868	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,080	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
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)	376,694	557,045	305,293	409,228	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.100247	10.015012	0.281740	41.470207	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	13,325	13,717	52,480	26,552	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.074293	0.246615	0.048431	2.690717	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:54 am

			Title XVIII	Hospital	PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	2,549,884		2,549,884	0	2,549,884 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	516,101		516,101	0	516,101 50.00
53.00	05300 ANESTHESIOLOGY	100,118		100,118	0	100,118 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,269,099		1,269,099	0	1,269,099 54.00
60.00	06000 LABORATORY	1,499,495		1,499,495	0	1,499,495 60.00
65.00	06500 RESPIRATORY THERAPY	508,286	0	508,286	0	508,286 65.00
66.00	06600 PHYSICAL THERAPY	1,042,425	0	1,042,425	0	1,042,425 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	63,092		63,092	0	63,092 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,098,118		1,098,118	0	1,098,118 73.00
76.00	03950 OTHER ANCILLARY COSTS	0		0	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	105,561		105,561	0	105,561 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1,929,487		1,929,487	0	1,929,487 88.00
90.00	09000 CLINIC	567,645		567,645	0	567,645 90.00
91.00	09100 EMERGENCY	1,753,646		1,753,646	51,848	1,805,494 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	661,622		661,622		661,622 92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	362,512		362,512	0	362,512 96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0 97.00
101.00	10100 HOME HEALTH AGENCY	725,666		725,666		725,666 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					
200.00	Subtotal (see instructions)	14,752,757	0	14,752,757	51,848	14,804,605 200.00
201.00	Less Observation Beds	661,622		661,622		661,622 201.00
202.00	Total (see instructions)	14,091,135	0	14,091,135	51,848	14,142,983 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:54 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,271,717		2,271,717			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	112	968,448	968,560	0.532854	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	487,502	487,502	0.205369	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	601,330	11,365,696	11,967,026	0.106050	0.000000	54.00
60.00	06000	LABORATORY	874,424	7,032,915	7,907,339	0.189633	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	167,770	2,027,580	2,195,350	0.231528	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	286,041	2,603,545	2,889,586	0.360752	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,068	206,919	435,987	0.144711	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	236,216	1,159,144	1,395,360	0.786978	0.000000	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	400	210,974	211,374	0.499404	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,036,762	1,036,762			88.00
90.00	09000	CLINIC	2,686	463,887	466,573	1.216626	0.000000	90.00
91.00	09100	EMERGENCY	172,661	3,358,439	3,531,100	0.496629	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	144,351	585,832	730,183	0.906104	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	394,009	394,009	0.920060	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	741,494	741,494			101.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,986,776	32,643,146	37,629,922			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,986,776	32,643,146	37,629,922			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.532854			50.00
53.00	05300 ANESTHESIOLOGY	0.205369			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.106050			54.00
60.00	06000 LABORATORY	0.189633			60.00
65.00	06500 RESPIRATORY THERAPY	0.231528			65.00
66.00	06600 PHYSICAL THERAPY	0.360752			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.144711			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.786978			73.00
76.00	03950 OTHER ANCILLARY COSTS	0.000000			76.00
76.97	07697 CARDIAC REHABILITATION	0.499404			76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	1.216626			90.00
91.00	09100 EMERGENCY	0.511312			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.906104			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.920060			96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000			97.00
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/25/2019 10:54 am

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		207,598	0	207,598	1,399	148.39	30.00
200.00	Total (lines 30 through 199)		207,598		207,598	1,399		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		644	95,563				
200.00	Total (lines 30 through 199)		644	95,563				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/25/2019 10:54 am

				Title XVIII		Hospital	PPS	
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	84,590	968,560	0.087336	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,307	487,502	0.004732	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,485	11,967,026	0.007227	571,620	4,131	54.00
60.00	06000	LABORATORY	57,237	7,907,339	0.007238	780,571	5,650	60.00
65.00	06500	RESPIRATORY THERAPY	23,877	2,195,350	0.010876	130,938	1,424	65.00
66.00	06600	PHYSICAL THERAPY	61,888	2,889,586	0.021418	156,026	3,342	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,936	435,987	0.009028	172,042	1,553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,348	1,395,360	0.031066	167,637	5,208	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	20,367	211,374	0.096355	123	12	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	82,688	1,036,762	0.079756	0	0	88.00
90.00	09000	CLINIC	104,024	466,573	0.222953	1,116	249	90.00
91.00	09100	EMERGENCY	53,579	3,531,100	0.015173	128,800	1,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,866	730,183	0.073771	101,580	7,494	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	26,635	394,009	0.067600	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50 through 199)	704,827	34,616,711		2,210,453	31,017	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0019		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/25/2019 10:54 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	1,399	0.00		644	30.00	
200.00		Total (lines 30 through 199)			0	1,399			644	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: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
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							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	97.00
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: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:54 am

				Title XVIII		Hospital	PPS		
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	968,560	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	487,502	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	11,967,026	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	7,907,339	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,195,350	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	2,889,586	0.000000	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	435,987	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,395,360	0.000000	73.00	
76.00	03950	OTHER ANCILLARY COSTS	0	0	0	0	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	211,374	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,036,762	0.000000	88.00	
90.00	09000	CLINIC	0	0	0	466,573	0.000000	90.00	
91.00	09100	EMERGENCY	0	0	0	3,531,100	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	730,183	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	394,009	0.000000	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0.000000	97.00	
200.00		Total (lines 50 through 199)	0	0	0	34,616,711		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 10:54 am

				Title XVIII		Hospital	PPS		
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	0	0	648,653	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	153,061	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	571,620	0	4,808,483	0	54.00	
60.00	06000	LABORATORY	0.000000	780,571	0	1,337,061	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	130,938	0	1,116,858	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	156,026	0	241,419	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	172,042	0	62,516	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	167,637	0	852,120	0	73.00	
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	123	0	95,063	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	0.000000	1,116	0	346,652	0	90.00	
91.00	09100	EMERGENCY	0.000000	128,800	0	1,123,055	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	101,580	0	348,879	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
200.00		Total (lines 50 through 199)		2,210,453	0	11,133,820	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0019		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/25/2019 10:54 am	
				Title XVIII		Hospital		PPS	
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		0.532854	648,653	0	0	345,637	50.00
53.00	05300	ANESTHESIOLOGY		0.205369	153,061	0	0	31,434	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.106050	4,808,483	0	0	509,940	54.00
60.00	06000	LABORATORY		0.189633	1,337,061	0	0	253,551	60.00
65.00	06500	RESPIRATORY THERAPY		0.231528	1,116,858	0	0	258,584	65.00
66.00	06600	PHYSICAL THERAPY		0.360752	241,419	0	0	87,092	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.144711	62,516	0	0	9,047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.786978	852,120	0	1,156	670,600	73.00
76.00	03950	OTHER ANCILLARY COSTS		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.499404	95,063	0	0	47,475	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
90.00	09000	CLINIC		1.216626	346,652	0	0	421,746	90.00
91.00	09100	EMERGENCY		0.496629	1,123,055	0	0	557,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.906104	348,879	0	0	316,121	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0.920060	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)			11,133,820	0	1,156	3,508,969	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			11,133,820	0	1,156	3,508,969	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0019		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/25/2019 10:54 am		
				Title XVIII		Hospital		PPS		
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	0	0						50.00
53.00	05300	ANESTHESIOLOGY	0	0						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0						54.00
60.00	06000	LABORATORY	0	0						60.00
65.00	06500	RESPIRATORY THERAPY	0	0						65.00
66.00	06600	PHYSICAL THERAPY	0	0						66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	910						73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0						76.00
76.97	07697	CARDIAC REHABILITATION	0	0						76.97
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	0	0						88.00
90.00	09000	CLINIC	0	0						90.00
91.00	09100	EMERGENCY	0	0						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0						92.00
OTHER REIMBURSABLE COST CENTERS										
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0						96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0						97.00
200.00		Subtotal (see instructions)	0	910						200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0							201.00
202.00		Net Charges (line 200 - line 201)	0	910						202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0019

Period:

Worksheet D

Component CCN: 14-U019

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/25/2019 10:54 am

			Title XVIII		Swing Beds - SNF		PPS		
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	0.532854	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.205369	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.106050	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.189633	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.231528	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.360752	0	0	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.144711	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.786978	0	0	0	0	73.00	
76.00	03950	OTHER ANCILLARY COSTS	0.000000	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.499404	0	0	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	1.216626	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.496629	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.906104	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.920060	0	0	0	0	96.00	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00	
200.00		Subtotal (see instructions)		0	0	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	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0019

Period:

Worksheet D

Component CCN: 14-U019

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/25/2019 10:54 am

			Title XVIII		Swing Beds - SNF		PPS		
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	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03950	OTHER ANCILLARY COSTS	0	0					76.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	0	0					90.00
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
	OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0					96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0					97.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 10:54 am
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,748 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,399 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)			1,036 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			146 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)			147 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			28 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			28 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			644 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)			146 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)			147 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			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,549,884 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,549,884 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,549,884 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)			1,822.65 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,173,787 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)			1,173,787 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/25/2019 10:54 am

		Title XVIII		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(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)					611,386	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,785,173	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)					95,563	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					31,017	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					126,580	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,658,593	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)					363	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,822.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					661,622	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	207,598	2,549,884	0.081415	661,622	53,866
91.00	Nursing School cost	0	2,549,884	0.000000	661,622	0
92.00	Allied health cost	0	2,549,884	0.000000	661,622	0
93.00	All other Medical Education	0	2,549,884	0.000000	661,622	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:54 am	
		Title XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,424,310		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.532854	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.205369	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.106050	571,620	60,620	54.00
60.00	06000 LABORATORY	0.189633	780,571	148,022	60.00
65.00	06500 RESPIRATORY THERAPY	0.231528	130,938	30,316	65.00
66.00	06600 PHYSICAL THERAPY	0.360752	156,026	56,287	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.144711	172,042	24,896	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.786978	167,637	131,927	73.00
76.00	03950 OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.499404	123	61	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.216626	1,116	1,358	90.00
91.00	09100 EMERGENCY	0.511312	128,800	65,857	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.906104	101,580	92,042	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.920060	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,210,453	611,386	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)		2,210,453		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0019 Component CCN: 14-U019	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 10:54 am	
		Title XVIII	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.532854	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.205369	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.106050	29,710	3,151	54.00
60.00	06000 LABORATORY	0.189633	93,853	17,798	60.00
65.00	06500 RESPIRATORY THERAPY	0.231528	36,832	8,528	65.00
66.00	06600 PHYSICAL THERAPY	0.360752	130,015	46,903	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.144711	53,910	7,801	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.786978	48,591	38,240	73.00
76.00	03950 OTHER ANCILLARY COSTS	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.499404	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.216626	0	0	90.00
91.00	09100 EMERGENCY	0.511312	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.906104	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.920060	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		392,911	122,421	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)		392,911		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 10:54 am
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		324,644	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		973,930	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		0	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		28.05	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.46	30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.51	31.00
32.00	Sum of lines 30 and 31		22.97	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.17	33.00
34.00	Disproportionate share adjustment (see instructions)		26,524	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 10:54 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)		0.000013853	0.000015424	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		93,739	124,154	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		23,627	92,860	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		116,487		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		1,441,585		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		1,712,055		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			1,712,055	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			104,224	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			1,816,279	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			1,816,279	61.00
62.00	Deductibles billed to program beneficiaries			233,956	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			43,072	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			27,997	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			43,072	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			1,610,320	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			0	70.93
70.94	HRR adjustment amount (see instructions)			-4,735	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 10:54 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	82,238	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	370,031	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		2,057,854	71.00
71.01	Sequestration adjustment (see instructions)		41,157	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		2,503,001	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-486,304	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		154,314	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/25/2019 10:54 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	324,644	0	324,644		324,644
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	973,930	0		973,930	973,930
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0817	0.0817	0.0817	0.0817	0
11.00	Disproportionate share adjustment (see instructions)	34.00	26,524	0	6,631	19,893	26,524
11.01	Uncompensated care payments	36.00	116,487	0	23,627	92,860	116,487
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	1,441,585	0	354,902	1,086,683	1,441,585
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,712,055	0	336,154	1,375,901	1,712,055
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,712,055	0	336,154	1,375,901	1,712,055
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	104,224	0	0	104,224	104,224
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/25/2019 10:54 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	336,154	1,480,125	1,816,279
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	104,224	0	0	104,224	104,224
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	104,224	0	0	104,224	104,224
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.244643	0.250000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			82,238		82,238
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				370,031	370,031
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/25/2019 10:54 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	324,644	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	973,930		1,298,574	1,298,574	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0817	0.0817	0.0817		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	26,524	0	26,524	26,524	11.00
11.01	Uncompensated care payments	36.00	116,487	23,627	92,860	116,487	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,441,585	23,627	1,417,958	1,441,585	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,712,055	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,712,055	0	1,712,055	1,712,055	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	104,224	0	104,224	104,224	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,816,279	1,816,279	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/25/2019 10:54 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	104,224	0	104,224	104,224	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	104,224	0	104,224	104,224	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	82,238	82,238		82,238	28.00
29.00	Low volume adjustment on or after October 1	70.97	370,031		370,031	370,031	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-4,735	0	-4,735	-4,735	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 10:54 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		910	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		3,508,969	2.00
3.00	OPPS payments		2,097,973	3.00
4.00	Outlier payment (see instructions)		3,300	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)		910	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,156	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)		1,156	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,156	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		246	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)		910	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)		2,101,273	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		429,923	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,672,260	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,672,260	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,672,260	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)		66,680	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		43,342	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		66,680	36.00
37.00	Subtotal (see instructions)		1,715,602	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,715,602	40.00
40.01	Sequestration adjustment (see instructions)		34,312	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,676,604	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		4,686	43.00
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: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/25/2019 10:54 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,947,321		1,676,212	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	12/19/2018	297,099	12/19/2018	392	3.01
3.02		06/26/2019	337,829		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	02/11/2019	79,248		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)		555,680		392	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)		2,503,001		1,676,604	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		4,686	6.01
6.02	SETTLEMENT TO PROGRAM		486,304		0	6.02
7.00	Total Medicare program liability (see instructions)		2,016,697		1,681,290	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: 14-0019
 Component CCN: 14-U019

 Period:
 From 07/01/2018
 To 06/30/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/25/2019 10:54 am

		Title XVIII		Swing Beds - SNF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		80,094		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)		80,094		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		80,094		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: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/25/2019 10:54 am	
		Title XVIII	Hospital	PPS	
				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: 14-0019

Period:

Worksheet E-2

Component CCN: 14-U019

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:54 am

		Title XVIII	Swing Beds - SNF	PPS	
			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)		85,307	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, see instructions)			0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		293	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)		85,307	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		85,307	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)		85,307	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		3,578	0	13.00
14.00	80% of Part B costs (line 12 x 80%)				14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		81,729	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)		81,729	0	19.00
19.01	Sequestration adjustment (see instructions)		1,635	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		80,094	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0	22.00
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

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

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet G

Date/Time Prepared:
11/25/2019 10:54 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	746,372	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	2,775,721	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	285,466	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	242,172	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)	4,049,731	0	0	0	11.00
FIXED ASSETS						
12.00	Land	617,632	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-472,602	0	0	0	14.00
15.00	Buildings	15,466,274	0	0	0	15.00
16.00	Accumulated depreciation	-11,911,093	0	0	0	16.00
17.00	Leasehold improvements	282,931	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6,805	0	0	0	19.00
20.00	Accumulated depreciation	-4,044,608	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	-4,967	0	0	0	22.00
23.00	Major movable equipment	15,938,608	0	0	0	23.00
24.00	Accumulated depreciation	-9,798,643	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	132,367	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,212,704	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	18,141,814	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	489,264	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,631,078	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,893,513	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	-2,167	0	0	0	37.00
38.00	Salaries, wages, and fees payable	132,663	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	300,000	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	367,342	0	0	0	43.00
44.00	Other current liabilities	1,703,635	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,501,473	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,095,542	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	492,129	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,587,671	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,089,144	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	19,804,369				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	19,804,369	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,893,513	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-1

Date/Time Prepared:
11/25/2019 10:54 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		20,152,674		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-801,240				2.00
3.00	Total (sum of line 1 and line 2)		19,351,434		0		3.00
4.00	CHANGE IN NET ASSETS	452,937		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)		452,937		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,804,371		0		11.00
12.00	ROUNDING	2		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)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,804,369		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	CHANGE IN NET ASSETS		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	ROUNDING		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: 14-0019

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2019 10:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,839,053		1,839,053	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	417,712		417,712	5.00
6.00	Swing bed - NF	14,952		14,952	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)	2,271,717		2,271,717	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)	2,271,717		2,271,717	17.00
18.00	Ancillary services	2,395,361	26,275,671	28,671,032	18.00
19.00	Outpatient services	319,698	4,426,227	4,745,925	19.00
20.00	RURAL HEALTH CLINIC	0	1,036,762	1,036,762	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		741,494	741,494	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	32,479	32,479	27.00
27.01	PHYSICIAN OFFICES	0	194,380	194,380	27.01
27.02	DME	0	394,009	394,009	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,986,776	33,101,022	38,087,798	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,300,203		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)		16,300,203		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0019

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-3

Date/Time Prepared:
11/25/2019 10:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	38,087,798	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,430,434	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,657,364	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,300,203	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,642,839	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	789,939	6.00
7.00	Income from investments	29,671	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	52,307	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	380	17.00
18.00	Revenue from sale of medical records and abstracts	1,960	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	119,759	22.00
23.00	Governmental appropriations	0	23.00
24.00	NURSING SERVICES	2,850	24.00
24.01	PRO FEES	-87,178	24.01
24.02	MISC INC	-68,089	24.02
25.00	Total other income (sum of lines 6-24)	841,599	25.00
26.00	Total (line 5 plus line 25)	-801,240	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-801,240	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0019

Period:

Worksheet H

HHA CCN: 14-7622

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:54 amHome Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	70,147	0	19,586	0	107,061	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	177,076	0	0	0	177,076	6.00
7.00	Physical Therapy	6,627	0	0	0	6,627	7.00
8.00	Occupational Therapy	17,714	0	0	0	17,714	8.00
9.00	Speech Pathology	5,707	0	0	0	5,707	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	6,233	0	0	0	6,233	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	2,638	0	0	143,669	146,307	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	286,142	0	19,586	143,669	466,725	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-2,157	104,904	-835	104,069		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	177,076	0	177,076		6.00
7.00	Physical Therapy	0	6,627	0	6,627		7.00
8.00	Occupational Therapy	0	17,714	0	17,714		8.00
9.00	Speech Pathology	0	5,707	0	5,707		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	6,233	0	6,233		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	146,307	0	146,307		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	-2,157	464,568	-835	463,733		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0019

Period:

Worksheet H-1

HHA CCN: 14-7622

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 10:54 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	104,069	0	0	0	0	104,069	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	177,076	0	0	0	0	177,076	6.00
7.00	Physical Therapy	6,627	0	0	0	0	6,627	7.00
8.00	Occupational Therapy	17,714	0	0	0	0	17,714	8.00
9.00	Speech Pathology	5,707	0	0	0	0	5,707	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	6,233	0	0	0	0	6,233	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	146,307	0	0	0	0	146,307	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	463,733	0	0	0	0	463,733	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	104,069						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	51,236	228,312					6.00
7.00	Physical Therapy	1,918	8,545					7.00
8.00	Occupational Therapy	5,126	22,840					8.00
9.00	Speech Pathology	1,651	7,358					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	1,804	8,037					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	42,334	188,641					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		463,733					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0019

Period:

Worksheet H-1

HHA CCN: 14-7622

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/25/2019 10:54 amHome Health
Agency I

PPS

		Capital Related Costs			Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)		
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)					
									1.00
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00	
2.00	Capital Related - Movable Equipment		0			0		2.00	
3.00	Plant Operation & Maintenance	0	0	0		0		3.00	
4.00	Transportation (see instructions)	0	0	0	0			4.00	
5.00	Administrative and General	0	0	0	0	-104,069	359,664	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	177,076	6.00	
7.00	Physical Therapy	0	0	0	0	0	6,627	7.00	
8.00	Occupational Therapy	0	0	0	0	0	17,714	8.00	
9.00	Speech Pathology	0	0	0	0	0	5,707	9.00	
10.00	Medical Social Services	0	0	0	0	0	0	10.00	
11.00	Home Health Aide	0	0	0	0	0	6,233	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0		0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	146,307	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	0	0	0	0	-104,069	359,664	24.00	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		104,069	25.00	
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.289351	26.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0019

Period:

Worksheet H-2

HHA CCN: 14-7622

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 10:54 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	6,202	8,675	14,019	28,896	6,785	1.00
2.00	Skilled Nursing Care	228,312	0	0	35,389	263,701	61,914	2.00
3.00	Physical Therapy	8,545	0	0	1,324	9,869	2,317	3.00
4.00	Occupational Therapy	22,840	0	0	3,540	26,380	6,194	4.00
5.00	Speech Pathology	7,358	0	0	1,141	8,499	1,996	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	8,037	0	0	1,246	9,283	2,180	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	188,641	0	0	527	189,168	44,416	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	463,733	6,202	8,675	57,186	535,796	125,802	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	12,889	6,893	0	6,461	0	35,767	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	12,889	6,893	0	6,461	0	35,767	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0019

Period:

Worksheet H-2

HHA CCN: 14-7622

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:
11/25/2019 10:54 amHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	2,058	0	0	99,749	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	325,615	0	2.00
3.00	Physical Therapy	0	0	0	0	12,186	0	3.00
4.00	Occupational Therapy	0	0	0	0	32,574	0	4.00
5.00	Speech Pathology	0	0	0	0	10,495	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	11,463	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	233,584	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	2,058	0	0	725,666	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	99,749						1.00
2.00	Skilled Nursing Care	325,615	51,891	377,506				2.00
3.00	Physical Therapy	12,186	1,942	14,128				3.00
4.00	Occupational Therapy	32,574	5,191	37,765				4.00
5.00	Speech Pathology	10,495	1,673	12,168				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	11,463	1,827	13,290				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	233,584	37,225	270,809				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	725,666	99,749	725,666				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.159365					21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0019
HHA CCN: 14-7622Period:
From 07/01/2018
To 06/30/2019Worksheet H-2
Part II
Date/Time Prepared:
11/25/2019 10:54 am

						Home Health Agency I	11/25/2019 10:54 am PPS	
Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,263	1,263	70,147	0	28,896	1,263	1.00
2.00	Skilled Nursing Care	0	0	177,076	0	263,701	0	2.00
3.00	Physical Therapy	0	0	6,627	0	9,869	0	3.00
4.00	Occupational Therapy	0	0	17,714	0	26,380	0	4.00
5.00	Speech Pathology	0	0	5,707	0	8,499	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	6,233	0	9,283	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	2,638	0	189,168	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,263	1,263	286,142		535,796	1,263	20.00
21.00	Total cost to be allocated	6,202	8,675	57,186		125,802	12,889	21.00
22.00	Unit cost multiplier	4.910530	6.868567	0.199852		0.234795	10.205067	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,263	0	1,263	0	17,030	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,263	0	1,263	0	17,030	0	20.00
21.00	Total cost to be allocated	6,893	0	6,461	0	35,767	0	21.00
22.00	Unit cost multiplier	5.457641	0.000000	5.115598	0.000000	2.100235	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0019

Period:

Worksheet H-2

HHA CCN: 14-7622

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/25/2019 10:54 amHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		14.00	16.00	19.00		
1.00	Administrative and General	7,303	0	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19)	7,303	0	0		20.00
21.00	Total cost to be allocated	2,058	0	0		21.00
22.00	Unit cost multiplier	0.281802	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0019

Period:

Worksheet H-3

HHA CCN: 14-7622

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 10:54 am

				Title XVIII		Home Health Agency I	PPS
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
		0	1.00	2.00	3.00	4.00	5.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	377,506		377,506	1,621	232.88
2.00	Physical Therapy	3.00	14,128	0	14,128	1,473	9.59
3.00	Occupational Therapy	4.00	37,765	0	37,765	599	63.05
4.00	Speech Pathology	5.00	12,168	0	12,168	40	304.20
5.00	Medical Social Services	6.00	0	0	0	0	0.00
6.00	Home Health Aide	7.00	13,290	0	13,290	89	149.33
7.00	Total (sum of lines 1-6)		454,857	0	454,857	3,822	
				Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00
Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,197		8.00
9.00	Physical Therapy		99914	0	1,132		9.00
10.00	Occupational Therapy		99914	0	448		10.00
11.00	Speech Pathology		99914	0	44		11.00
12.00	Medical Social Services		99914	0	0		12.00
13.00	Home Health Aide		99914	0	99		13.00
14.00	Total (sum of lines 8-13)			0	2,920		14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
		0	1.00	2.00	3.00	4.00	5.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	853	853	5,894	0.144723
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000
				Program Visits		Cost of Services	
				Part B		Part B	
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,197		0	278,757	1.00
2.00	Physical Therapy	0	1,132		0	10,856	2.00
3.00	Occupational Therapy	0	448		0	28,246	3.00
4.00	Speech Pathology	0	44		0	13,385	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	99		0	14,784	6.00
7.00	Total (sum of lines 1-6)	0	2,920		0	346,028	7.00
		6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0019

Period:

Worksheet H-3

HHA CCN: 14-7622

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 10:54 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1			
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00	10.00	11.00
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	1,898	0	0	275	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	278,757						1.00	
2.00	Physical Therapy	10,856						2.00	
3.00	Occupational Therapy	28,246						3.00	
4.00	Speech Pathology	13,385						4.00	
5.00	Medical Social Services	0						5.00	
6.00	Home Health Aide	14,784						6.00	
7.00	Total (sum of lines 1-6)	346,028						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0019

Period:

Worksheet H-3

HHA CCN: 14-7622

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/25/2019 10:54 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.360752	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.144711	5,894	853	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.786978	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0019 HHA CCN: 14-7622	Period: From 07/01/2018 To 06/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 11/25/2019 10:54 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	470,903	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	26,590	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	11,727	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	1,627	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	5,689	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	516,536	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	516,536	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	516,536	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	516,536	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	516,536	31.00
31.01	Sequestration adjustment (see instructions)		0	10,331	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	506,205	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-0019
HHA CCN: 14-7622Period:
From 07/01/2018
To 06/30/2019

Worksheet H-5

Date/Time Prepared:
11/25/2019 10:54 am

		Home Health Agency I		PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		0		506,205
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		506,205
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		506,205
		Contractor Number		NPR Date (Mo/Day/Yr)	
		0		1.00 2.00	
8.00	Name of Contractor				8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/25/2019 10:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		104,224	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		2.84	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		104,224	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0019

Period:

Worksheet M-1

Component CCN: 14-3446

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:54 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	0	268,617	268,617	0	268,617	1.00
2.00 Physician Assistant	0	70,356	70,356	0	70,356	2.00
3.00 Nurse Practitioner	112,388	159,750	272,138	0	272,138	3.00
4.00 Visiting Nurse	0	0	0	0	0	4.00
5.00 Other Nurse	0	143,062	143,062	0	143,062	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	0	0	0	0	0	9.00
10.00 Subtotal (sum of lines 1 through 9)	112,388	641,785	754,173	0	754,173	10.00
11.00 Physician Services Under Agreement	0	0	0	0	0	11.00
12.00 Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00 Other Costs Under Agreement	0	0	0	0	0	13.00
14.00 Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00 Medical Supplies	0	10,878	10,878	0	10,878	15.00
16.00 Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00 Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00 Professional Liability Insurance	0	0	0	0	0	18.00
19.00 Other Health Care Costs	0	498	498	0	498	19.00
20.00 Allowable GME Costs	0	0	0	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	11,376	11,376	0	11,376	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	112,388	653,161	765,549	0	765,549	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	0	35	35	0	35	29.00
30.00 Administrative Costs	58,571	335,041	393,612	-3,801	389,811	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	58,571	335,076	393,647	-3,801	389,846	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	170,959	988,237	1,159,196	-3,801	1,155,395	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0019

Period:

Worksheet M-1

Component CCN: 14-3446

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:54 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	268,617	1.00
2.00	Physician Assistant	0	70,356	2.00
3.00	Nurse Practitioner	0	272,138	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	143,062	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	754,173	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	10,878	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	498	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,376	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	765,549	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	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	35	29.00
30.00	Administrative Costs	128,058	517,869	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	128,058	517,904	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	128,058	1,283,453	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0019

Period:

Worksheet M-2

Component CCN: 14-3446

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 10:54 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	0.81	2,834	4,200	3,402		1.00
2.00	Physician Assistant	0.67	683	2,100	1,407		2.00
3.00	Nurse Practitioner	2.19	4,176	2,100	4,599		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.67	7,693		9,408	9,408	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)	3.67	7,693			9,408	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)					765,549	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)					765,549	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)					517,904	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					646,034	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,163,938	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,163,938	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,163,938	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,929,487	20.00

Health Financial Systems		HSHS GOOD SHEPHERD HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0019	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-3446		Date/Time Prepared: 11/25/2019 10:54 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)			1,929,487	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			7,062	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,922,425	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,408	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)			9,408	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			204.34	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)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		204.34	204.34	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,718	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	351,056	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	351,056	16.00
16.01	Total program charges (see instructions)(from contractor's records)			289,853	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			254,727	16.04
16.05	Total program cost (see instructions)		0	254,727	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			32,647	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			51,441	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			254,727	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			3,242	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			257,969	22.00
23.00	Allowable bad debts (see instructions)			8,848	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			5,751	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			8,848	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)			263,720	26.00
26.01	Sequestration adjustment (see instructions)			5,274	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			244,634	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)			13,812	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: 14-0019 Component CCN: 14-3446	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 10:54 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)		754,173	754,173	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.001306	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	985	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	1,817	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	2,802	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		765,549	765,549	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,163,938	1,163,938	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.003660	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	4,260	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	7,062	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	122	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	57.89	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	56	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	3,242	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)			7,062	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)			3,242	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0019 Component CCN: 14-3446	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 10:54 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		226,044	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		02/11/2019	18,590	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		18,590	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		244,634	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		13,812	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		258,446	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00