

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-0059

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

Worksheet S
Parts I-III
Date/Time Prepared:
11/26/2019 1:51 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/26/2019	Time: 1:51 pm
	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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	number of times reopened = 0-9.
	(4) Reopened		
	(5) Amended		

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 JERSEY COMMUNITY HOSPITAL DIST (14-0059) 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) BETH KING

Officer or Administrator of Provider(s)

CFO

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	-10,611	54,626	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
10.00	RURAL HEALTH CLINIC I	0		267,168		0	10.00
200.00	Total	0	-10,611	321,794	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: 14-0059		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 1:51 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 400 MAPLE SUMMIT ROAD			PO Box:				1.00	
2.00	City: JERSEYVILLE			State: IL		Zip Code: 62052		County: JERSEY 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			JERSEY COMMUNITY HOSPITAL DIST	140059	41180	1	07/11/1996	N P O 3.00
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF			JERSEY COMMUNITY HOSPITAL	14U059	41180		08/27/1993	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								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC			JCH MEDICAL GROUP JERSEYVILLE	148538	41180		01/01/2015	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)							11	21.00
								1.00	2.00 3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						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.						1	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0059		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 1:51 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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.	1						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.	1						27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:			
					1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	1						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.	1						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.	07/01/2018					06/30/2019	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	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N							56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N							59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0059		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 1:51 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §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

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
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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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			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.	N	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	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)				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.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

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		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						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
						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
						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
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:	343,583		0		0	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N		118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				N		122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	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							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0059		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 1:51 pm	
						1.00		2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)					N			
						1.00		2.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:		Contractor's Name:		Contractor's Number:		141.00		
142.00	Street:		PO Box:				142.00		
143.00	City:		State:		Zip Code:		143.00		
						1.00			
144.00	Are provider based physicians' costs included in Worksheet A?					Y		144.00	
						1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
						1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N		149.00	
						Part A		Part B	
						1.00		2.00	
						Title V		Title XIX	
						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		155.00
156.00	Subprovider - IPF		N		N		N		156.00
157.00	Subprovider - IRF		N		N		N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF		N		N		N		159.00
160.00	HOME HEALTH AGENCY		N		N		N		160.00
161.00	CMHC				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
			0		1.00		2.00		3.00
									4.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
						1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					N		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)					9.99		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)					10/01/2018		12/31/2018	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 1:51 pm
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0059		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part II Date/Time Prepared: 11/26/2019 1:51 pm	
		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.	Y					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	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/06/2018	Y	11/06/2018		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/26/2019 1:51 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	JILL		NELSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-655-4706		JILL.NELSON@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	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: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	42	15,330	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)		42	15,330	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	0.00	0	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)		46	16,790	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						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		46				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: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,444	9	2,021		1.00
2.00	HMO and other (see instructions)	345	59			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	147	0	224		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,591	9	2,245		7.00
8.00	INTENSIVE CARE UNIT	202	10	309		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,793	19	2,554	0.00	253.19
15.00	CAH visits	0	0	0		14.00
16.00	SUBPROVIDER - IPF					15.00
17.00	SUBPROVIDER - IRF					16.00
18.00	SUBPROVIDER					17.00
19.00	SKILLED NURSING FACILITY					18.00
20.00	NURSING FACILITY					19.00
21.00	OTHER LONG TERM CARE					20.00
22.00	HOME HEALTH AGENCY					21.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					22.00
24.00	HOSPICE					23.00
24.10	HOSPICE (non-distinct part)			0		24.00
25.00	CMHC - CMHC					24.10
26.00	RHC (CONSOLIDATED)	20,983	14,926	70,520	0.00	82.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	335.22
28.00	Observation Bed Days		5	792		27.00
29.00	Ambulance Trips	1,474				28.00
30.00	Employee discount days (see instruction)			12		29.00
31.00	Employee discount days - IRF			0		30.00
32.00	Labor & delivery days (see instructions)	0	0	0		31.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.00
33.00	LTCH non-covered days	0				32.01
33.01	LTCH site neutral days and discharges	0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	513	8	729	1.00
2.00 HMO and other (see instructions)			82	20		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	513	8	729	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/26/2019 1:51 pm

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	20,390,855	0	20,390,855	697,255.00	29.24 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		3,049,546	0	3,049,546	25,227.00	120.88 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		2,937,705	9,799	2,947,504	145,401.00	20.27 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		2,968,391	-234,311	2,734,080	112,834.00	24.23 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,299,472	0	1,299,472	16,437.00	79.06 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		13,600	0	13,600	66.00	206.06 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,380,443	0	3,380,443		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		849,326	0	849,326		
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		300,310	0	300,310		
24.00	Wage-related costs (RHC/FQHC)		1,079,928	0	1,079,928		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
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		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/26/2019 1:51 pm

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	182,142	0	182,142	6,305.00	28.89
27.00	Administrative & General	5.00	2,461,088	0	2,461,088	84,008.00	29.30
28.00	Administrative & General under contract (see inst.)		394,519	0	394,519	7,492.00	52.66
29.00	Maintenance & Repairs	6.00	266,148	0	266,148	8,491.00	31.34
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00
31.00	Laundry & Linen Service	8.00	41,272	0	41,272	3,215.00	12.84
32.00	Housekeeping	9.00	215,294	0	215,294	17,768.00	12.12
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	306,468	0	306,468	21,985.00	13.94
35.00	Dietary under contract (see instructions)		30,660	0	30,660	767.00	39.97
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	465,422	0	465,422	11,809.00	39.41
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	362,333	0	362,333	16,771.00	21.60
42.00	Social Service	17.00	0	0	0	0.00	0.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/26/2019 1:51 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	14,828,783	-9,799	14,818,984	534,886.00	27.70	1.00
2.00	Excluded area salaries (see instructions)	2,968,391	-234,311	2,734,080	112,834.00	24.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)	11,860,392	224,512	12,084,904	422,052.00	28.63	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,313,072	0	1,313,072	16,503.00	79.57	4.00
5.00	Subtotal wage-related costs (see inst.)	3,380,443	0	3,380,443	0.00	27.97	5.00
6.00	Total (sum of lines 3 thru 5)	16,553,907	224,512	16,778,419	438,555.00	38.26	6.00
7.00	Total overhead cost (see instructions)	4,725,346	0	4,725,346	178,611.00	26.46	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/26/2019 1:51 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		638,639	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)		3,471,636	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)		33,258	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)		7,703	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		98,413	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		1,345,418	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		14,940	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		5,610,007	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: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/26/2019 1:51 pm

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	1,299,472	5,610,007	1.00
2.00	Hospital	1,299,472	4,229,769	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			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	1,380,238	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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0059

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

Worksheet S-7

Date/Time Prepared:
11/26/2019 1:51 pm

		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.				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	08/27/1993		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	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	10	10 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	8	8 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	25	25 20.00
21.00		RMC	0	4	4 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	39	39 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	3	3 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	14	14 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	14	14 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0059

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

Worksheet S-7

Date/Time Prepared:
11/26/2019 1:51 pm

		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	20	20	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	10	10	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	147	147	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).			41180	41180	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: 14-0059 Component CCN: 14-8538		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/26/2019 1:51 pm	
			RHC I		Cost			
			1.00					
Clinic Address and Identification								
1.00	Street				390 MAPLE SUMMIT ROAD		1.00	
				City	State	ZIP Code		
				1.00	2.00	3.00		
2.00	City, State, ZIP Code, County				JERSEYVILLE IL 62052		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		17:00	
				08:00				11.00
				1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				Y		5 13.00	
				Provider name		CCN number		
				1.00		2.00		
14.00	RHC/FQHC name, CCN number				JCH MEDICAL GROUP CARROLLTON		148537	
14.01					JCH MEDICAL GROUP HARDIN		148539	
14.02					JCH MEDICAL GROUP ROODHOUSE		148540	
14.03					JCH MEDICAL GROUP JERSEYVILLE - II		148550	
14.04							14.04	
				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				JERSEY		2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0059

Period:

Worksheet S-8

Component CCN: 14-8538

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 1:51 pm

RHC I

Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)							
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00
		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: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/26/2019 1:51 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.342307 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,816,145		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,637,059		5.00
6.00	Medicaid charges	12,935,504		6.00
7.00	Medicaid cost (line 1 times line 6)	4,427,914		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)	974,710		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)	974,710		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)	114,118	77,192	191,310 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	39,063	77,192	116,255 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	39,063	77,192	116,255 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,466,646		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	251,376		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	386,733		27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,079,913		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	847,326		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	963,581		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,938,291		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0059

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

Worksheet A

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		983,652	983,652	204,986	1,188,638 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		824,002	824,002	74,399	898,401 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	182,142	4,289,574	4,471,716	98,413	4,570,129 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,461,088	2,821,522	5,282,610	-105,666	5,176,944 5.00
6.00	00600	MAINTENANCE & REPAIRS	266,148	400,018	666,166	0	666,166 6.00
7.00	00700	OPERATION OF PLANT	0	877,810	877,810	-3,022	874,788 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,272	41,275	82,547	0	82,547 8.00
9.00	00900	HOUSEKEEPING	215,294	94,533	309,827	0	309,827 9.00
10.00	01000	DIETARY	306,468	262,343	568,811	0	568,811 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	465,422	46,646	512,068	0	512,068 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	114	114	0	114 14.00
15.00	01500	PHARMACY	0	0	0	0	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	362,333	313,128	675,461	0	675,461 16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	683,004	683,004	0	683,004 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	961,480	178,790	1,140,270	-720	1,139,550 30.00
31.00	03100	INTENSIVE CARE UNIT	458,814	41,493	500,307	0	500,307 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	473,726	652,577	1,126,303	-273,493	852,810 50.00
51.00	05100	RECOVERY ROOM	68,013	8,740	76,753	0	76,753 51.00
53.00	05300	ANESTHESIOLOGY	0	19,628	19,628	0	19,628 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	951,133	1,034,452	1,985,585	-44,590	1,940,995 54.00
60.00	06000	LABORATORY	919,114	799,723	1,718,837	-87,875	1,630,962 60.00
66.00	06600	PHYSICAL THERAPY	0	1,081,891	1,081,891	0	1,081,891 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	289,244	52,877	342,121	0	342,121 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	469,041	469,041	245,743	714,784 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	937,519	937,519	0	937,519 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	496,889	1,717,524	2,214,413	0	2,214,413 73.00
75.00	07500	ASC (NON-DISTINCT PART)	600,350	181,647	781,997	0	781,997 75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,987,251	1,575,509	7,562,760	-162,990	7,399,770 88.00
90.00	09000	CLINIC	0	0	0	677,787	677,787 90.00
91.00	09100	EMERGENCY	1,916,283	1,319,336	3,235,619	0	3,235,619 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	760,409	177,292	937,701	0	937,701 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,182,873	21,885,660	40,068,533	622,972	40,691,505 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,898,631	1,541,631	3,440,262	-622,972	2,817,290 192.00
192.01	19201	WELLNESS CENTER	309,351	208,171	517,522	0	517,522 192.01
192.03	19203	COMMUNITY RELATIONS	0	227,663	227,663	0	227,663 192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	20,390,855	23,863,125	44,253,980	0	44,253,980 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0059

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

Worksheet A

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-113,124	1,075,514	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	898,401	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-948,102	3,622,027	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-499,951	4,676,993	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	666,166	6.00
7.00	00700	OPERATION OF PLANT	0	874,788	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,547	8.00
9.00	00900	HOUSEKEEPING	0	309,827	9.00
10.00	01000	DIETARY	-164,162	404,649	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	512,068	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	114	14.00
15.00	01500	PHARMACY	-432	-432	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,078	666,383	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-683,004	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-50,865	1,088,685	30.00
31.00	03100	INTENSIVE CARE UNIT	0	500,307	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	852,810	50.00
51.00	05100	RECOVERY ROOM	0	76,753	51.00
53.00	05300	ANESTHESIOLOGY	0	19,628	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-139,841	1,801,154	54.00
60.00	06000	LABORATORY	-17,137	1,613,825	60.00
66.00	06600	PHYSICAL THERAPY	0	1,081,891	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	342,121	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	714,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	937,519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,214,413	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	781,997	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-245,853	7,153,917	88.00
90.00	09000	CLINIC	-246,102	431,685	90.00
91.00	09100	EMERGENCY	-1,661,870	1,573,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-34,758	902,943	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,814,279	35,877,226	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,817,290	192.00
192.01	19201	WELLNESS CENTER	-916	516,606	192.01
192.03	19203	COMMUNITY RELATIONS	0	227,663	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,815,195	39,438,785	200.00

Provider CCN: 14-0059

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

Worksheet A-6
Date/Time Prepared:
11/26/2019 1:51 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - WORKERS COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	98,413	1.00	
	TOTALS		0	98,413		
	B - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	3,980	1.00	
	TOTALS		0	3,980		
	C - RENTAL EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	202,345	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	73,060	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	
	TOTALS		0	275,405		
	D - PHYSICIAN OFFICE EXPENSE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,022	1.00	
	TOTALS		0	3,022		
	E - MEDICAL GROUP ADMIN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	78,076	50,644	1.00	
	TOTALS		78,076	50,644		
	G - RHC LABORATORY					
1.00	RURAL HEALTH CLINIC	88.00	87,875	0	1.00	
	TOTALS		87,875	0		
	H - PROVIDER-BASED CLINIC					
1.00	CLINIC	90.00	312,387	365,400	1.00	
	TOTALS		312,387	365,400		
	I - OR SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	245,743	1.00	
	TOTALS		0	245,743		
500.00	Grand Total: Increases		478,338	1,042,607	500.00	

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - WORKERS COMPENSATION						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	98,413	0		
	TOTALS		0	98,413			
1.00	B - PROPERTY INSURANCE						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	3,980	12		
	TOTALS		0	3,980			
1.00	C - RENTAL EXPENSE						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	3,273	10		
	ADULTS & PEDIATRICS	30.00	0	720	10		
3.00	OPERATING ROOM	50.00	0	27,750	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44,590	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	122,145	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	76,927	0		6.00
	TOTALS		0	275,405			
1.00	D - PHYSICIAN OFFICE EXPENSE						1.00
	OPERATION OF PLANT	7.00	0	3,022	0		
	TOTALS		0	3,022			
1.00	E - MEDICAL GROUP ADMIN						1.00
	RURAL HEALTH CLINIC	88.00	78,076	50,644	0		
	TOTALS		78,076	50,644			
1.00	G - RHC LABORATORY						1.00
	LABORATORY	60.00	87,875	0	0		
	TOTALS		87,875	0			
1.00	H - PROVIDER-BASED CLINIC						1.00
	PHYSICIANS' PRIVATE OFFICES	192.00	312,387	365,400	0		
	TOTALS		312,387	365,400			
1.00	I - OR SUPPLIES						1.00
	OPERATING ROOM	50.00	0	245,743	0		
	TOTALS		0	245,743			
500.00	Grand Total: Decreases		478,338	1,042,607			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	55,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	18,624,019	484,009	0	484,009	0	3.00
4.00	Building Improvements	6,626,029	202,337	0	202,337	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	12,649,725	787,757	0	787,757	255,429	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,954,773	1,474,103	0	1,474,103	255,429	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,954,773	1,474,103	0	1,474,103	255,429	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	55,000	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	19,108,028	0				3.00
4.00	Building Improvements	6,828,366	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	13,182,053	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	39,173,447	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	39,173,447	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	764,344	0	219,308	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	824,002	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,588,346	0	219,308	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	983,652				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	824,002				2.00
3.00	Total (sum of lines 1-2)	0	1,807,654				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	25,991,394	0	25,991,394	0.663495	2,641	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,182,053	0	13,182,053	0.336505	1,339	2.00
3.00	Total (sum of lines 1-2)	39,173,447	0	39,173,447	1.000000	3,980	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	2,641	763,869	202,345	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1,339	824,002	73,060	2.00
3.00	Total (sum of lines 1-2)	0	0	3,980	1,587,871	275,405	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed 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	106,659	2,641	0	0	1,075,514	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,339	0	0	898,401	2.00
3.00	Total (sum of lines 1-2)	106,659	3,980	0	0	1,973,915	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0059

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

Worksheet A-8

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-112,649	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)	B	-301	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,129	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-475	CAP REL COSTS-BLDG & FIXT	1.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,240,067			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-162,825	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others	B	-70,837	ADMINISTRATIVE & GENERAL	5.00	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	B	-432	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,078	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,337	DIETARY	10.00	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	*** Cost Center Deleted ***	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	A	-683,004	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0059

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

Worksheet A-8

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00			
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC REV	B	-102,979	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	PHYSICIAN RECRUITMENT	A	-70,303	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	NON PATIENT LAB REV	B	-1,537	LABORATORY	60.00	0	33.02
33.03	LIFE LINE REVENUE	B	-29,305	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	BAD DEBTS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	SELF INSURANCE CLAIMS	A	-811,569	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	ADVERTISING	A	-74,612	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING SALARIES	A	-97,755	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MARKETING BENEFITS	A	-26,521	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	LOBBYING EXPENSES	A	-13,064	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTISING	A	-916	WELLNESS CENTER	192.01	0	33.10
33.11	MISCELLANEOUS EXPENSE	A	0		0.00	0	33.11
33.12	FOUNDATION SALARIES	A	-39,306	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	FOUNDATION BENEFITS	A	-10,664	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	RECYCLING REVENUE - MISC	B	0	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	NON-ALLOWABLE CHAMBER DUES	A	-360	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	GIFT SHOP REVENUE	B	0		0.00	0	33.16
33.17	NP - HOSPITALIST	A	-120,064	RURAL HEALTH CLINIC	88.00	0	33.17
33.18	HOSPITALIST BENEFITS	A	-53,916	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	PATIENT TELEVISION EXPENSE	A	0	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	EMS TRAINING REVENUE	B	-34,758	AMBULANCE SERVICES	95.00	0	33.20
33.21	ED PHYSICIAN BENEFITS	A	-45,432	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,815,195				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0059

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2019 1:51 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	88.00	RURAL HEALTH CLINIC	125,789	125,789	0	0	0	1.00
2.00	91.00	EMERGENCY	952,192	952,192	0	0	0	2.00
3.00	91.00	EMERGENCY	13,600	0	13,600	211,500	66	3.00
4.00	91.00	EMERGENCY	702,789	702,789	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	50,865	50,865	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	139,841	139,841	0	0	0	6.00
7.00	60.00	LABORATORY	15,600	15,600	0	0	0	7.00
8.00	90.00	CLINIC	246,102	246,102	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			2,246,778	2,233,178	13,600		66	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	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	6,711	336	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	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			6,711	336	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	88.00	RURAL HEALTH CLINIC	0	0	0	125,789		1.00
2.00	91.00	EMERGENCY	0	0	0	952,192		2.00
3.00	91.00	EMERGENCY	0	6,711	6,889	6,889		3.00
4.00	91.00	EMERGENCY	0	0	0	702,789		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	50,865		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	139,841		6.00
7.00	60.00	LABORATORY	0	0	0	15,600		7.00
8.00	90.00	CLINIC	0	0	0	246,102		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	6,711	6,889	2,240,067		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

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	1,075,514	1,075,514			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	898,401		898,401		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,622,027	1,776	0	3,623,803	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,676,993	139,049	322,032	441,320	5,579,394
6.00	00600	MAINTENANCE & REPAIRS	666,166	38,296	0	47,725	752,187
7.00	00700	OPERATION OF PLANT	874,788	0	0	0	874,788
8.00	00800	LAUNDRY & LINEN SERVICE	82,547	3,754	2,089	7,401	95,791
9.00	00900	HOUSEKEEPING	309,827	2,355	0	38,606	350,788
10.00	01000	DIETARY	404,649	22,290	1,846	54,956	483,741
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	512,068	1,776	0	83,459	597,303
14.00	01400	CENTRAL SERVICES & SUPPLY	114	4,299	0	0	4,413
15.00	01500	PHARMACY	-432	0	0	0	-432
16.00	01600	MEDICAL RECORDS & LIBRARY	666,383	9,352	10,417	64,973	751,125
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,088,685	38,202	14,527	172,412	1,313,826
31.00	03100	INTENSIVE CARE UNIT	500,307	14,210	2,917	82,274	599,708
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	852,810	27,753	94,986	84,948	1,060,497
51.00	05100	RECOVERY ROOM	76,753	2,631	0	12,196	91,580
53.00	05300	ANESTHESIOLOGY	19,628	1,050	83	0	20,761
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,801,154	43,423	176,708	170,556	2,191,841
60.00	06000	LABORATORY	1,613,825	19,982	33,320	149,057	1,816,184
66.00	06600	PHYSICAL THERAPY	1,081,891	21,207	4,611	0	1,107,709
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	342,121	18,193	13,884	51,867	426,065
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	714,784	0	0	0	714,784
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	937,519	0	0	0	937,519
73.00	07300	DRUGS CHARGED TO PATIENTS	2,214,413	7,435	30,737	89,102	2,341,687
75.00	07500	ASC (NON-DISTINCT PART)	781,997	25,116	13,994	107,654	928,761
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	7,153,917	220,316	12,106	1,075,381	8,461,720
90.00	09000	CLINIC	431,685	9,345	55,872	56,017	552,919
91.00	09100	EMERGENCY	1,573,749	44,466	5,099	343,626	1,966,940
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	902,943	32,530	81,651	136,356	1,153,480
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,877,226	748,806	876,879	3,269,886	35,175,079
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,438	0	0	3,438
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,817,290	151,112	2,766	298,444	3,269,612
192.01	19201	WELLNESS CENTER	516,606	171,552	18,756	55,473	762,387
192.03	19203	COMMUNITY RELATIONS	227,663	606	0	0	228,269
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	39,438,785	1,075,514	898,401	3,623,803	39,438,785

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

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	5,579,394					5.00
6.00	00600	MAINTENANCE & REPAIRS	123,945	876,132				6.00
7.00	00700	OPERATION OF PLANT	144,147	0	1,018,935			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,784	3,669	4,267	119,511		8.00
9.00	00900	HOUSEKEEPING	57,802	2,302	2,677	8,240	421,809	9.00
10.00	01000	DIETARY	79,710	21,786	25,337	0	21,996	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	98,423	1,736	2,019	0	1,294	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	727	4,202	4,887	282	2,588	14.00
15.00	01500	PHARMACY	0	0	0	0	3,882	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	123,770	9,141	10,630	0	6,469	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	216,491	37,338	43,424	39,178	87,984	30.00
31.00	03100	INTENSIVE CARE UNIT	98,819	13,888	16,152	2,212	11,645	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	174,748	27,126	31,547	6,859	43,992	50.00
51.00	05100	RECOVERY ROOM	15,090	2,571	2,990	0	1,294	51.00
53.00	05300	ANESTHESIOLOGY	3,421	1,026	1,193	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	361,169	42,441	49,359	12,100	23,290	54.00
60.00	06000	LABORATORY	299,269	19,531	22,714	0	16,821	60.00
66.00	06600	PHYSICAL THERAPY	182,527	20,728	24,106	0	24,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	70,207	17,781	20,680	416	14,233	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,781	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	154,483	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	385,861	7,266	8,451	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	153,040	24,548	28,549	7,482	28,466	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,394,323	215,338	250,439	148	47,874	88.00
90.00	09000	CLINIC	91,109	9,134	10,623	15	0	90.00
91.00	09100	EMERGENCY	324,110	43,461	50,544	24,986	54,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	190,069	31,795	36,977	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,876,825	556,808	647,565	101,918	390,755	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	567	3,360	3,908	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	538,763	147,697	171,770	3,326	2,588	192.00
192.01	19201	WELLNESS CENTER	125,625	167,675	195,004	14,267	28,466	192.01
192.03	19203	COMMUNITY RELATIONS	37,614	592	688	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,579,394	876,132	1,018,935	119,511	421,809	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	632,570					10.00
11.00	01100	CAFETERIA	524,201	524,201				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	700,775			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	17,099		14.00
15.00	01500	PHARMACY	0	0	0	0	3,450	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,816	0	0	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	93,973	66,661	165,434	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,396	28,786	57,339	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	21,210	60,819	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	8,430	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,515	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,146	0	0	0	54.00
60.00	06000	LABORATORY	0	77,268	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,210	40,108	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,397	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,702	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,120	0	0	3,450	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	45,451	78,072	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	7,575	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	75,752	148,669	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	48,481	141,904	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	632,570	502,991	700,775	17,099	3,450	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	7,575	0	0	0	192.00
192.01	19201	WELLNESS CENTER	0	13,635	0	0	0	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	0	0	0	192.03
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)	632,570	524,201	700,775	17,099	3,450	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	932,951				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	140,589	0	2,204,898	0	30.00
31.00	03100	INTENSIVE CARE UNIT	80,839	0	923,784	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	232,745	0	1,659,543	0	50.00
51.00	05100	RECOVERY ROOM	0	0	121,955	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	27,916	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,481	0	2,821,827	0	54.00
60.00	06000	LABORATORY	55,955	0	2,307,742	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	1,359,654	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	56,025	0	666,725	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	839,962	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,101,704	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,758,835	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	1,294,369	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	10,377,417	0	88.00
90.00	09000	CLINIC	0	0	663,800	0	90.00
91.00	09100	EMERGENCY	132,787	0	2,821,592	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	157,530	0	1,760,236	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	932,951	0	33,711,959	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	11,273	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,141,331	0	192.00
192.01	19201	WELLNESS CENTER	0	0	1,307,059	0	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	267,163	0	192.03
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	932,951	0	39,438,785	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0059

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,776	1,776	1,776	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	139,049	322,032	461,081	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	38,296	0	38,296	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,754	2,089	5,843	8.00
9.00	00900	HOUSEKEEPING	0	2,355	0	2,355	9.00
10.00	01000	DIETARY	0	22,290	1,846	24,136	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,776	0	1,776	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,299	0	4,299	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,352	10,417	19,769	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	38,202	14,527	52,729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	14,210	2,917	17,127	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	27,753	94,986	122,739	50.00
51.00	05100	RECOVERY ROOM	0	2,631	0	2,631	51.00
53.00	05300	ANESTHESIOLOGY	0	1,050	83	1,133	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,423	176,708	220,131	54.00
60.00	06000	LABORATORY	0	19,982	33,320	53,302	60.00
66.00	06600	PHYSICAL THERAPY	0	21,207	4,611	25,818	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,193	13,884	32,077	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	7,435	30,737	38,172	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	25,116	13,994	39,110	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	220,316	12,106	232,422	88.00
90.00	09000	CLINIC	0	9,345	55,872	65,217	90.00
91.00	09100	EMERGENCY	0	44,466	5,099	49,565	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	32,530	81,651	114,181	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	748,806	876,879	1,625,685	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,438	0	3,438	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	151,112	2,766	153,878	192.00
192.01	19201	WELLNESS CENTER	0	171,552	18,756	190,308	192.01
192.03	19203	COMMUNITY RELATIONS	0	606	0	606	192.03
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	1,075,514	898,401	1,973,915	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	461,298					5.00
6.00	00600	MAINTENANCE & REPAIRS	10,248	48,567				6.00
7.00	00700	OPERATION OF PLANT	11,918	0	11,918			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,305	203	50	7,405		8.00
9.00	00900	HOUSEKEEPING	4,779	128	31	511	7,823	9.00
10.00	01000	DIETARY	6,590	1,208	296	0	408	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,138	96	24	0	24	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60	233	57	17	48	14.00
15.00	01500	PHARMACY	0	0	0	0	72	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,233	507	124	0	120	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,900	2,070	508	2,427	1,631	30.00
31.00	03100	INTENSIVE CARE UNIT	8,170	770	189	137	216	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,448	1,504	369	425	816	50.00
51.00	05100	RECOVERY ROOM	1,248	143	35	0	24	51.00
53.00	05300	ANESTHESIOLOGY	283	57	14	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,862	2,353	577	750	432	54.00
60.00	06000	LABORATORY	24,744	1,083	266	0	312	60.00
66.00	06600	PHYSICAL THERAPY	15,091	1,149	282	0	456	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,805	986	242	26	264	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,738	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,773	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,903	403	99	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	12,653	1,361	334	464	528	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	115,274	11,934	2,929	9	888	88.00
90.00	09000	CLINIC	7,533	506	124	1	0	90.00
91.00	09100	EMERGENCY	26,798	2,409	591	1,548	1,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	15,715	1,763	433	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	403,209	30,866	7,574	6,315	7,247	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	47	186	46	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,545	8,187	2,009	206	48	192.00
192.01	19201	WELLNESS CENTER	10,387	9,295	2,281	884	528	192.01
192.03	19203	COMMUNITY RELATIONS	3,110	33	8	0	0	192.03
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)	461,298	48,567	11,918	7,405	7,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	32,665					10.00
11.00	01100	CAFETERIA	27,069	27,069				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	10,099			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	4,714		14.00
15.00	01500	PHARMACY	0	0	0	0	64	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,643	0	0	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	4,853	3,442	2,386	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	743	1,486	826	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,095	876	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	121	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	78	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,364	0	0	0	54.00
60.00	06000	LABORATORY	0	3,992	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,095	578	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,039	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,675	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	626	0	0	64	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	2,347	1,125	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	391	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,912	2,142	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,503	2,045	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,665	25,974	10,099	4,714	64	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	391	0	0	0	192.00
192.01	19201	WELLNESS CENTER	0	704	0	0	0	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	8	201.00
202.00		TOTAL (sum lines 118 through 201)	32,665	27,069	10,099	4,714	72	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
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Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,428				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,887	92,918	0	92,918	30.00
31.00	03100	INTENSIVE CARE UNIT	2,810	32,514	0	32,514	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,090	150,404	0	150,404	50.00
51.00	05100	RECOVERY ROOM	0	4,208	0	4,208	51.00
53.00	05300	ANESTHESIOLOGY	0	1,565	0	1,565	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,658	260,211	0	260,211	54.00
60.00	06000	LABORATORY	1,945	85,717	0	85,717	60.00
66.00	06600	PHYSICAL THERAPY	0	42,796	0	42,796	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,947	43,045	0	43,045	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,777	0	11,777	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,448	0	15,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,311	0	71,311	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	57,975	0	57,975	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	364,372	0	364,372	88.00
90.00	09000	CLINIC	0	73,408	0	73,408	90.00
91.00	09100	EMERGENCY	4,615	92,757	0	92,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	5,476	142,183	0	142,183	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,428	0	1,542,609	0	1,542,609
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,717	0	3,717	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	209,410	0	209,410	192.00
192.01	19201	WELLNESS CENTER	0	214,414	0	214,414	192.01
192.03	19203	COMMUNITY RELATIONS	0	3,757	0	3,757	192.03
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	8	0	8	201.00
202.00		TOTAL (sum lines 118 through 201)	32,428	0	1,973,915	0	1,973,915

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0059

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

Worksheet B-1

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	159,855					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		897,060				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	264	0	20,208,713			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,667	321,553	2,461,088	-5,579,394	33,859,823	5.00
6.00	00600	MAINTENANCE & REPAIRS	5,692	0	266,148	0	752,187	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	874,788	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	558	2,086	41,272	0	95,791	8.00
9.00	00900	HOUSEKEEPING	350	0	215,294	0	350,788	9.00
10.00	01000	DIETARY	3,313	1,843	306,468	0	483,741	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	264	0	465,422	0	597,303	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	639	0	0	0	4,413	14.00
15.00	01500	PHARMACY	0	0	0	432	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,390	10,401	362,333	0	751,125	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,678	14,505	961,480	0	1,313,826	30.00
31.00	03100	INTENSIVE CARE UNIT	2,112	2,913	458,814	0	599,708	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,125	94,844	473,726	0	1,060,497	50.00
51.00	05100	RECOVERY ROOM	391	0	68,013	0	91,580	51.00
53.00	05300	ANESTHESIOLOGY	156	83	0	0	20,761	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,454	176,444	951,133	0	2,191,841	54.00
60.00	06000	LABORATORY	2,970	33,270	831,239	0	1,816,184	60.00
66.00	06600	PHYSICAL THERAPY	3,152	4,604	0	0	1,107,709	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,704	13,863	289,244	0	426,065	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	714,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	937,519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,105	30,691	496,889	0	2,341,687	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,733	13,973	600,350	0	928,761	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	32,746	12,088	5,997,050	0	8,461,720	88.00
90.00	09000	CLINIC	1,389	55,789	312,387	0	552,919	90.00
91.00	09100	EMERGENCY	6,609	5,091	1,916,283	0	1,966,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,835	81,529	760,409	0	1,153,480	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,296	875,570	18,235,042	-5,578,962	29,596,117	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	511	0	0	0	3,438	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,460	2,762	1,664,320	0	3,269,612	192.00
192.01	19201	WELLNESS CENTER	25,498	18,728	309,351	0	762,387	192.01
192.03	19203	COMMUNITY RELATIONS	90	0	0	0	228,269	192.03
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)	1,075,514	898,401	3,623,803		5,579,394	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.728060	1.001495	0.179319		0.164779	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,776		461,298	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000088		0.013624	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: 14-0059

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

Worksheet B-1

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		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	133,232				6.00
7.00	00700	OPERATION OF PLANT	0	133,232			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	558	558	8,050		8.00
9.00	00900	HOUSEKEEPING	350	350	555	326	9.00
10.00	01000	DIETARY	3,313	3,313	0	17	59,627 10.00
11.00	01100	CAFETERIA	0	0	0	0	49,412 11.00
13.00	01300	NURSING ADMINISTRATION	264	264	0	1	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	639	639	19	2	0 14.00
15.00	01500	PHARMACY	0	0	0	3	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,390	1,390	0	5	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	5,678	5,678	2,639	68	8,858 30.00
31.00	03100	INTENSIVE CARE UNIT	2,112	2,112	149	9	1,357 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,125	4,125	462	34	0 50.00
51.00	05100	RECOVERY ROOM	391	391	0	1	0 51.00
53.00	05300	ANESTHESIOLOGY	156	156	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,454	6,454	815	18	0 54.00
60.00	06000	LABORATORY	2,970	2,970	0	13	0 60.00
66.00	06600	PHYSICAL THERAPY	3,152	3,152	0	19	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	2,704	2,704	28	11	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	1,105	1,105	0	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,733	3,733	504	22	0 75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	32,746	32,746	10	37	0 88.00
90.00	09000	CLINIC	1,389	1,389	1	0	0 90.00
91.00	09100	EMERGENCY	6,609	6,609	1,683	42	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	4,835	4,835	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,673	84,673	6,865	302	59,627 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	511	511	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,460	22,460	224	2	0 192.00
192.01	19201	WELLNESS CENTER	25,498	25,498	961	22	0 192.01
192.03	19203	COMMUNITY RELATIONS	90	90	0	0	0 192.03
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)	876,132	1,018,935	119,511	421,809	632,570 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.575988	7.647825	14.846087	1,293.892638	10.608785 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48,567	11,918	7,405	7,823	32,665 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.364530	0.089453	0.919876	23.996933	0.547822 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: 14-0059

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

Worksheet B-1

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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	346				11.00
13.00	01300	NURSING ADMINISTRATION	0	190,291			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,652,303		14.00
15.00	01500	PHARMACY	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	13,272	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	44	44,923	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	19	15,570	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	14	16,515	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,289	0	0	51.00
53.00	05300	ANESTHESIOLOGY	1	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43	0	0	0	54.00
60.00	06000	LABORATORY	51	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14	10,891	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	714,784	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	937,519	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8	0	0	100	73.00
75.00	07500	ASC (NON-DISTINCT PART)	30	21,200	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	50	40,370	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				1,889	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	32	38,533	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	332	190,291	1,652,303	100	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	5	0	0	0	192.00
192.01	19201	WELLNESS CENTER	9	0	0	0	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	0	0	192.03
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)	524,201	700,775	17,099	3,450	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,515.031792	3.682649	0.010349	34.500000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	27,069	10,099	4,714	72	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	78.234104	0.053071	0.002853	0.640000	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: 14-0059

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

Worksheet B-1

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		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	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	WELLNESS CENTER	192.01
192.03	19203	COMMUNITY RELATIONS	192.03
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)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	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: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

			Title XVIII		Hospital		PPS		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
					Total Costs	RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,204,898		2,204,898	0	2,204,898	30.00	
31.00	03100	INTENSIVE CARE UNIT	923,784		923,784	0	923,784	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,659,543		1,659,543	0	1,659,543	50.00	
51.00	05100	RECOVERY ROOM	121,955		121,955	0	121,955	51.00	
53.00	05300	ANESTHESIOLOGY	27,916		27,916	0	27,916	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,821,827		2,821,827	0	2,821,827	54.00	
60.00	06000	LABORATORY	2,307,742		2,307,742	0	2,307,742	60.00	
66.00	06600	PHYSICAL THERAPY	1,359,654	0	1,359,654	0	1,359,654	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	666,725		666,725	0	666,725	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	839,962		839,962	0	839,962	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,101,704		1,101,704	0	1,101,704	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,758,835		2,758,835	0	2,758,835	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	1,294,369		1,294,369	0	1,294,369	75.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,377,417		10,377,417	0	10,377,417	88.00	
90.00	09000	CLINIC	663,800		663,800	0	663,800	90.00	
91.00	09100	EMERGENCY	2,821,592		2,821,592	6,889	2,828,481	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	606,419		606,419		606,419	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,760,236		1,760,236	0	1,760,236	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	34,318,378	0	34,318,378	6,889	34,325,267	200.00	
201.00		Less Observation Beds	606,419		606,419		606,419	201.00	
202.00		Total (see instructions)	33,711,959	0	33,711,959	6,889	33,718,848	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/26/2019 1:51 pm	
					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	1,463,354		1,463,354			30.00
31.00	03100	INTENSIVE CARE UNIT	417,741		417,741			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	783,438	4,859,896	5,643,334	0.294071	0.000000	50.00
51.00	05100	RECOVERY ROOM	39,768	182,892	222,660	0.547718	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	225,391	2,477,418	2,702,809	0.010329	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,207,514	25,144,951	26,352,465	0.107080	0.000000	54.00
60.00	06000	LABORATORY	1,437,170	14,220,308	15,657,478	0.147389	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	523,224	6,182,279	6,705,503	0.202767	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	445,247	3,067,822	3,513,069	0.189784	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	455,129	514,995	970,124	0.865830	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	507,226	692,640	1,199,866	0.918189	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,209,833	4,571,569	5,781,402	0.477191	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	40,532	2,682,704	2,723,236	0.475305	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	11,125,133	11,125,133			88.00
90.00	09000	CLINIC	0	498,147	498,147	1.332538	0.000000	90.00
91.00	09100	EMERGENCY	1,239,525	8,841,368	10,080,893	0.279895	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	99,259	1,174,502	1,273,761	0.476085	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,153,481	2,153,481	0.817391	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,094,351	88,390,105	98,484,456			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,094,351	88,390,105	98,484,456			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.294071		50.00
51.00	05100	RECOVERY ROOM	0.547718		51.00
53.00	05300	ANESTHESIOLOGY	0.010329		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107080		54.00
60.00	06000	LABORATORY	0.147389		60.00
66.00	06600	PHYSICAL THERAPY	0.202767		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.189784		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.865830		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.918189		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.477191		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.475305		75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	1.332538		90.00
91.00	09100	EMERGENCY	0.280578		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.476085		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.817391		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

			Title XIX		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
					Total Costs	RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,204,898		2,204,898	0	2,204,898	30.00	
31.00	03100	INTENSIVE CARE UNIT	923,784		923,784	0	923,784	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,659,543		1,659,543	0	1,659,543	50.00	
51.00	05100	RECOVERY ROOM	121,955		121,955	0	121,955	51.00	
53.00	05300	ANESTHESIOLOGY	27,916		27,916	0	27,916	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,821,827		2,821,827	0	2,821,827	54.00	
60.00	06000	LABORATORY	2,307,742		2,307,742	0	2,307,742	60.00	
66.00	06600	PHYSICAL THERAPY	1,359,654	0	1,359,654	0	1,359,654	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	666,725		666,725	0	666,725	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	839,962		839,962	0	839,962	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,101,704		1,101,704	0	1,101,704	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,758,835		2,758,835	0	2,758,835	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	1,294,369		1,294,369	0	1,294,369	75.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,377,417		10,377,417	0	10,377,417	88.00	
90.00	09000	CLINIC	663,800		663,800	0	663,800	90.00	
91.00	09100	EMERGENCY	2,821,592		2,821,592	6,889	2,828,481	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	606,419		606,419		606,419	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,760,236		1,760,236	0	1,760,236	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	34,318,378	0	34,318,378	6,889	34,325,267	200.00	
201.00		Less Observation Beds	606,419		606,419		606,419	201.00	
202.00		Total (see instructions)	33,711,959	0	33,711,959	6,889	33,718,848	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/26/2019 1:51 pm	
					Title XIX		Hospital	Cost
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,463,354		1,463,354			30.00
31.00	03100	INTENSIVE CARE UNIT	417,741		417,741			31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	783,438	4,859,896	5,643,334	0.294071	0.000000	50.00
51.00	05100	RECOVERY ROOM	39,768	182,892	222,660	0.547718	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	225,391	2,477,418	2,702,809	0.010329	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,207,514	25,144,951	26,352,465	0.107080	0.000000	54.00
60.00	06000	LABORATORY	1,437,170	14,220,308	15,657,478	0.147389	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	523,224	6,182,279	6,705,503	0.202767	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	445,247	3,067,822	3,513,069	0.189784	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	455,129	514,995	970,124	0.865830	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	507,226	692,640	1,199,866	0.918189	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,209,833	4,571,569	5,781,402	0.477191	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	40,532	2,682,704	2,723,236	0.475305	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	11,125,133	11,125,133	0.932790	0.000000	88.00
90.00	09000	CLINIC	0	498,147	498,147	1.332538	0.000000	90.00
91.00	09100	EMERGENCY	1,239,525	8,841,368	10,080,893	0.279895	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	99,259	1,174,502	1,273,761	0.476085	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,153,481	2,153,481	0.817391	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,094,351	88,390,105	98,484,456			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,094,351	88,390,105	98,484,456			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		92,918	2,151	90,767	2,813	32.27	30.00
31.00	INTENSIVE CARE UNIT		32,514		32,514	309	105.22	31.00
200.00	Total (lines 30 through 199)		125,432		123,281	3,122		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		1,444	46,598				
31.00	INTENSIVE CARE UNIT		202	21,254				
200.00	Total (lines 30 through 199)		1,646	67,852				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared: 11/26/2019 1:51 pm
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	150,404	5,643,334	0.026652	542,346	14,455	50.00
51.00 05100 RECOVERY ROOM	4,208	222,660	0.018899	25,616	484	51.00
53.00 05300 ANESTHESIOLOGY	1,565	2,702,809	0.000579	115,563	67	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	260,211	26,352,465	0.009874	1,206,170	11,910	54.00
60.00 06000 LABORATORY	85,717	15,657,478	0.005475	1,430,694	7,833	60.00
66.00 06600 PHYSICAL THERAPY	42,796	6,705,503	0.006382	284,048	1,813	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	43,045	3,513,069	0.012253	370,270	4,537	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,777	970,124	0.012140	226,263	2,747	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15,448	1,199,866	0.012875	319,648	4,115	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	71,311	5,781,402	0.012335	877,381	10,822	73.00
75.00 07500 ASC (NON-DISTINCT PART)	57,975	2,723,236	0.021289	40,532	863	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	364,372	11,125,133	0.032752	0	0	88.00
90.00 09000 CLINIC	73,408	498,147	0.147362	0	0	90.00
91.00 09100 EMERGENCY	92,757	10,080,893	0.009201	886,710	8,159	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	25,556	1,273,761	0.020063	86,654	1,739	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	1,300,550	94,449,880		6,411,895	69,544	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0059		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/26/2019 1:51 pm		
					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	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	2,813	0.00	1,444	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	309	0.00	202	31.00			
200.00		Total (lines 30 through 199)	0	0	3,122		1,646	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	
31.00	03100	INTENSIVE CARE UNIT	0							31.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/26/2019 1:51 pm

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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/26/2019 1:51 pm

				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	5,643,334	0.000000		50.00
51.00	05100	RECOVERY ROOM	0	0	0	222,660	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,702,809	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,352,465	0.000000		54.00
60.00	06000	LABORATORY	0	0	0	15,657,478	0.000000		60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,705,503	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,513,069	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	970,124	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,199,866	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,781,402	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	2,723,236	0.000000		75.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	11,125,133	0.000000		88.00
90.00	09000	CLINIC	0	0	0	498,147	0.000000		90.00
91.00	09100	EMERGENCY	0	0	0	10,080,893	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,273,761	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0	0	0	94,449,880			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/26/2019 1:51 pm

				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	542,346	0	1,775,153	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	25,616	0	83,370	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.000000	115,563	0	378,641	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,206,170	0	10,674,300	0	54.00	
60.00	06000	LABORATORY	0.000000	1,430,694	0	2,202,181	0	60.00	
66.00	06600	PHYSICAL THERAPY	0.000000	284,048	0	25,383	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	370,270	0	1,168,281	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	226,263	0	155,693	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	319,648	0	326,777	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	877,381	0	2,691,459	0	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	40,532	0	1,819,288	0	75.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	886,710	0	3,016,415	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	86,654	0	590,409	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)		6,411,895	0	24,907,350	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/26/2019 1:51 pm

			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	0.294071	1,775,153	0	0	522,021	50.00
51.00	05100	RECOVERY ROOM	0.547718	83,370	0	0	45,663	51.00
53.00	05300	ANESTHESIOLOGY	0.010329	378,641	0	0	3,911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107080	10,674,300	0	0	1,143,004	54.00
60.00	06000	LABORATORY	0.147389	2,202,181	0	0	324,577	60.00
66.00	06600	PHYSICAL THERAPY	0.202767	25,383	0	0	5,147	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.189784	1,168,281	0	0	221,721	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.865830	155,693	0	0	134,804	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.918189	326,777	0	0	300,043	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.477191	2,691,459	0	17,196	1,284,340	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.475305	1,819,288	0	0	864,717	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	1.332538	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.279895	3,016,415	0	0	844,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.476085	590,409	0	0	281,085	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.817391	0	0	0	0	95.00
200.00		Subtotal (see instructions)		24,907,350	0	17,196	5,975,312	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		24,907,350	0	17,196	5,975,312	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/26/2019 1:51 pm

				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
51.00	05100	RECOVERY ROOM	0	0		51.00
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
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,206		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
	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					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	8,206		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	8,206		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0059

Period:

Worksheet D

Component CCN:14-U059

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/26/2019 1:51 pm

				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	0.294071	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.547718	0	0	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.010329	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107080	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.147389	0	0	0	0	60.00	
66.00	06600	PHYSICAL THERAPY	0.202767	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.189784	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.865830	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.918189	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.477191	0	0	0	0	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.475305	0	0	0	0	75.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	1.332538	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.279895	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.476085	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.817391	0	0	0	0	95.00	
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:14-0059

Period:

Worksheet D

Component CCN:14-U059

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/26/2019 1:51 pm

			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
51.00	05100	RECOVERY ROOM	0	0					51.00
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
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
	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								
95.00	09500	AMBULANCE SERVICES	0						95.00
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: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 1:51 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,037	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,813	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,021	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		112	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)		112	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,444	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)		74	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)		73	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		224.47	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		231.33	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,204,898	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)		25,141	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)		25,909	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)		51,050	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,153,848	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)		2,153,848	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)		765.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,105,642	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)		1,105,642	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0059

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

Worksheet D-1

Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	923,784	309	2,989.59	202	603,897
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,859,996
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,569,535
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					67,852
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					69,544
52.00	Total Program excludable cost (sum of lines 50 and 51)					137,396
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,432,139
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					16,611
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					16,887
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					33,498
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00	Program routine service cost (line 9 x line 71)					
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00	Per diem capital-related costs (line 75 ÷ line 2)					
77.00	Program capital-related costs (line 9 x line 76)					
78.00	Inpatient routine service cost (line 74 minus line 77)					
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00	Inpatient routine service cost per diem limitation					
82.00	Inpatient routine service cost limitation (line 9 x line 81)					
83.00	Reasonable inpatient routine service costs (see instructions)					
84.00	Program inpatient ancillary services (see instructions)					
85.00	Utilization review - physician compensation (see instructions)					
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					792
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					765.68
89.00	Observation bed cost (line 87 x line 88) (see instructions)					606,419

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0059		Period: From 07/01/2018 To 06/30/2019		Worksheet D-1 Date/Time Prepared: 11/26/2019 1:51 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)			
		1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	92,918	2,204,898	0.042142	606,419	25,556			90.00
91.00	Nursing School cost	0	2,204,898	0.000000	606,419	0			91.00
92.00	Allied health cost	0	2,204,898	0.000000	606,419	0			92.00
93.00	All other Medical Education	0	2,204,898	0.000000	606,419	0			93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 1:51 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			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		871,598		30.00
31.00	03100	INTENSIVE CARE UNIT		274,987		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.294071	542,346	159,488	50.00
51.00	05100	RECOVERY ROOM	0.547718	25,616	14,030	51.00
53.00	05300	ANESTHESIOLOGY	0.010329	115,563	1,194	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107080	1,206,170	129,157	54.00
60.00	06000	LABORATORY	0.147389	1,430,694	210,869	60.00
66.00	06600	PHYSICAL THERAPY	0.202767	284,048	57,596	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.189784	370,270	70,271	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.865830	226,263	195,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.918189	319,648	293,497	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.477191	877,381	418,678	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.475305	40,532	19,265	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.332538	0	0	90.00
91.00	09100	EMERGENCY	0.280578	886,710	248,791	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.476085	86,654	41,255	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,411,895	1,859,996	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)		6,411,895		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0059 Component CCN: 14-U059	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 1:51 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	PPS	
		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		876		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.294071	0	0	50.00
51.00	05100 RECOVERY ROOM	0.547718	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.010329	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107080	1,344	144	54.00
60.00	06000 LABORATORY	0.147389	6,476	954	60.00
66.00	06600 PHYSICAL THERAPY	0.202767	87,730	17,789	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.189784	3,757	713	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.865830	3,183	2,756	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.918189	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.477191	26,255	12,529	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.475305	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	1.332538	0	0	90.00
91.00	09100 EMERGENCY	0.280578	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.476085	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		128,745	34,885	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)		128,745		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/26/2019 1:51 pm
		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)		582,809	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,270,212	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)		43.22	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)		4.33	30.00
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		4.33	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/26/2019 1:51 pm	
		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)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		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)	2,853,021			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	3,365,851			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			3,237,644	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			228,985	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)			3,466,629	59.00
60.00	Primary payer payments			953	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			3,465,676	61.00
62.00	Deductibles billed to program beneficiaries			485,380	62.00
63.00	Coinsurance billed to program beneficiaries			1,023	63.00
64.00	Allowable bad debts (see instructions)			119,263	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			77,521	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			101,847	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3,056,794	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)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			154	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-1,295	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			1,440	70.93
70.94	HRR adjustment amount (see instructions)			-10,216	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/26/2019 1:51 pm	
		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	108,746	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	602,807	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)		3,758,430	71.00	
71.01	Sequestration adjustment (see instructions)		75,169	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		3,693,872	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)		-10,611	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	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)		96,946	287,677	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.9987586328	1.0009528966	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		-120	274	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		1.0000	0.9955	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	-1,295	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: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2019 1:51 pm

		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	582,809	0	582,809		582,809
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,270,212	0		2,270,212	2,270,212
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	
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	
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	0.0000	0.0000	0.0000	0.0000	
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0
11.01	Uncompensated care payments	36.00	0	0	0	0	0
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	2,853,021	0	582,809	2,270,212	2,853,021
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	3,365,851	0	691,892	2,673,959	3,365,851
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,237,644	0	664,621	2,573,023	3,237,644
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	228,985	0	46,799	182,186	228,985
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ acquisition 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: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2019 1:51 pm

		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	711,420	2,755,209	3,466,629
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	228,985	0	46,799	182,186	228,985
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	228,985	0	46,799	182,186	228,985
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.152857	0.218788	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			108,746		108,746
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				602,807	602,807
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/26/2019 1:51 pm

		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	582,809	582,809		582,809	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,270,212		2,270,212	2,270,212	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	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	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	2,853,021	582,809	2,270,212	2,853,021	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	3,365,851	691,892	2,673,959	3,365,851	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,237,644	664,621	2,573,023	3,237,644	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	228,985	46,799	182,186	228,985	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			711,420	2,755,209	3,466,629	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/26/2019 1:51 pm

		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	228,985	46,799	182,186	228,985	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	228,985	46,799	182,186	228,985	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	108,746	108,746		108,746	28.00
29.00	Low volume adjustment on or after October 1	70.97	602,807		602,807	602,807	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	1,440	-723	2,163	1,440	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	154	-120	274	154	30.01
31.00	HRR adjustment (see instructions)	70.94	-10,216	0	-10,216	-10,216	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-1,295	0	-1,295	-1,295	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.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/26/2019 1:51 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,206	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,975,312	2.00
3.00	OPPS payments		5,539,800	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,206	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		17,196	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)		17,196	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)		17,196	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,990	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		8,206	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)		5,539,800	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)		1,103,986	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,444,020	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,444,020	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,444,020	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)		164,519	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		106,937	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		131,232	36.00
37.00	Subtotal (see instructions)		4,550,957	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)		4,550,957	40.00
40.01	Sequestration adjustment (see instructions)		91,019	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,405,312	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		54,626	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: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/26/2019 1:51 pm

		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		3,694,688		4,409,574	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	01/28/2019	816	01/28/2019	4,262	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)		-816		-4,262	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)		3,693,872		4,405,312	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		54,626	6.01
6.02	SETTLEMENT TO PROGRAM		10,611		0	6.02
7.00	Total Medicare program liability (see instructions)		3,683,261		4,459,938	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:14-0059

Period:

Worksheet E-1

Component CCN:14-U059

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:

11/26/2019 1:51 pm

		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		44,892		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)		44,892		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)		44,892		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/26/2019 1:51 pm

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:14-0059

Period:

Worksheet E-2

Component CCN:14-U059

From 07/01/2018

To 06/30/2019

Date/Time Prepared:
11/26/2019 1:51 pm

		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)		45,808	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		147	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)		45,808	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		45,808	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)		45,808	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		45,808	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)		45,808	0	19.00
19.01	Sequestration adjustment (see instructions)		916	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		44,892	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: 14-0059

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

Worksheet G

Date/Time Prepared:
11/26/2019 1:51 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,958,471	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	19,885,148	0	0	0	4.00
5.00	Other receivable	192,435	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,817,916	0	0	0	6.00
7.00	Inventory	666,063	0	0	0	7.00
8.00	Prepaid expenses	286,798	0	0	0	8.00
9.00	Other current assets	269,000	0	0	0	9.00
10.00	Due from other funds	4,536,177	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,976,176	0	0	0	11.00
FIXED ASSETS						
12.00	Land	55,000	0	0	0	12.00
13.00	Land improvements	538,288	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	21,262,431	0	0	0	15.00
16.00	Accumulated depreciation	-11,744,742	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,856,020	0	0	0	23.00
24.00	Accumulated depreciation	-14,204,961	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,762,036	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	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	114,643	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	114,643	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	28,852,855	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,710,098	0	0	0	37.00
38.00	Salaries, wages, and fees payable	858,980	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,041,504	0	0	0	40.00
41.00	Deferred income	58,515	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	15,200	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,684,297	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,554,071	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,274,944	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,829,015	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,513,312	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	20,339,543	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	20,339,543	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	28,852,855	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0059

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

Worksheet G-1

Date/Time Prepared:
11/26/2019 1:51 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		20,741,766		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-402,223				2.00
3.00	Total (sum of line 1 and line 2)		20,339,543		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		20,339,543		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,339,543		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0059

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2019 1:51 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,613,154		2,613,154	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,613,154		2,613,154	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	551,526		551,526	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)	551,526		551,526	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,164,680		3,164,680	17.00
18.00	Ancillary services	6,720,383	69,164,490	75,884,873	18.00
19.00	Outpatient services	1,517,218	12,291,537	13,808,755	19.00
20.00	RURAL HEALTH CLINIC	0	10,239,642	10,239,642	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,161,308	2,161,308	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS PRIVATE OFFICES	0	8,046,186	8,046,186	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,402,281	101,903,163	113,305,444	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		44,253,980		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)		44,253,980		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0059

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

Worksheet G-3

Date/Time Prepared:
11/26/2019 1:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	113,305,444	1.00
2.00	Less contractual allowances and discounts on patients' accounts	72,087,597	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,217,847	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	44,253,980	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,036,133	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	213,050	6.00
7.00	Income from investments	112,649	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	301	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	152,260	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	467,788	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	WELLNESS CENTER	487,753	24.00
24.01	PROPERTY TAX AND REPLACEMENT TAXES	380,447	24.01
24.02	GRANT REVENUE	807,393	24.02
24.03	GAIN ON SALES OF ASSETS	-1,458	24.03
24.04	POPULATION HEALTH	13,386	24.04
25.00	Total other income (sum of lines 6-24)	2,633,569	25.00
26.00	Total (line 5 plus line 25)	-402,564	26.00
27.00	RECONILING ITEM	-332	27.00
27.01	ROUNDING	-9	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-341	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-402,223	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0059	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/26/2019 1:51 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		228,985	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)		6.42	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)		228,985	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: 14-0059

Period:

Worksheet M-1

Component CCN: 14-8538

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 1:51 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	2,458,009	10,900	2,468,909	-2,386	2,466,523
2.00	Physician Assistant	331,019	0	331,019	0	331,019
3.00	Nurse Practitioner	940,456	0	940,456	0	940,456
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	106,836	0	106,836	0	106,836
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	87,875	87,875
9.00	Other Facility Health Care Staff Costs	1,297,584	0	1,297,584	0	1,297,584
10.00	Subtotal (sum of lines 1 through 9)	5,133,904	10,900	5,144,804	85,489	5,230,293
11.00	Physician Services Under Agreement	0	49,135	49,135	0	49,135
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	49,135	49,135	0	49,135
15.00	Medical Supplies	0	404,943	404,943	-539	404,404
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	404,943	404,943	-539	404,404
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,133,904	464,978	5,598,882	84,950	5,683,832
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	154,855	154,855	-4,560	150,295
30.00	Administrative Costs	853,347	955,676	1,809,023	-243,380	1,565,643
31.00	Total Facility Overhead (sum of lines 29 and 30)	853,347	1,110,531	1,963,878	-247,940	1,715,938
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,987,251	1,575,509	7,562,760	-162,990	7,399,770

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0059

Period:

Worksheet M-1

Component CCN: 14-8538

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 1:51 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-125,789	2,340,734	1.00
2.00	Physician Assistant	0	331,019	2.00
3.00	Nurse Practitioner	-120,064	820,392	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	106,836	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	87,875	8.00
9.00	Other Facility Health Care Staff Costs	0	1,297,584	9.00
10.00	Subtotal (sum of lines 1 through 9)	-245,853	4,984,440	10.00
11.00	Physician Services Under Agreement	0	49,135	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	49,135	14.00
15.00	Medical Supplies	0	404,404	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	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	404,404	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-245,853	5,437,979	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	150,295	29.00
30.00	Administrative Costs	0	1,565,643	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,715,938	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-245,853	7,153,917	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN:14-0059

Period:

Worksheet M-2

Component CCN:14-8538

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 1:51 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	8.32	37,071	4,200	34,944	1.00
2.00	Physician Assistant	2.71	10,058	2,100	5,691	2.00
3.00	Nurse Practitioner	6.67	23,391	2,100	14,007	3.00
4.00	Subtotal (sum of lines 1 through 3)	17.70	70,520		54,642	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)	17.70	70,520		70,520	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				5,437,979	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)				5,437,979	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)				1,715,938	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				3,223,500	15.00
16.00	Total overhead (sum of lines 14 and 15)				4,939,438	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				4,939,438	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				4,939,438	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				10,377,417	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-0059 Component CCN:14-8538	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/26/2019 1:51 pm		
			Title XVIII	RHC I	Cost	
					1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			10,377,417	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			237,582	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			10,139,835	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			70,520	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)			70,520	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			143.79	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)			143.79	143.79	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			10,492	10,491	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			1,508,645	1,508,501	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	3,017,146	16.00
16.01	Total program charges (see instructions)(from contractor's records)				2,779,516	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				57,668	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				62,597	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.)				2,104,704	16.04
16.05	Total program cost (see instructions)			0	2,167,301	16.05
17.00	Primary payer amounts				388	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				323,669	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				479,636	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				2,166,913	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				118,736	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				2,285,649	22.00
23.00	Allowable bad debts (see instructions)				102,951	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				66,918	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				461	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)				0	25.50
25.99	Demonstration payment adjustment amount before sequestration				0	25.99
26.00	Net reimbursable amount (see instructions)				2,352,567	26.00
26.01	Sequestration adjustment (see instructions)				47,051	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				2,038,348	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)				267,168	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: 14-0059 Component CCN: 14-8538	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/26/2019 1:51 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		4,984,440	4,984,440	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001491	0.005339	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		7,432	26,612	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		65,412	25,042	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		72,844	51,654	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		5,437,979	5,437,979	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		4,939,438	4,939,438	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.013395	0.009499	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		66,164	46,920	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		139,008	98,574	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		427	1,529	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		325.55	64.47	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		216	751	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		70,319	48,417	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)			237,582	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)			118,736	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0059 Component CCN: 14-8538	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/26/2019 1:51 pm	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			2,088,524	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50			01/28/2019	50,176	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)			-50,176	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			2,038,348	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			267,168	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			2,305,516	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00