

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: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet S
Parts I-III
Date/Time Prepared:
8/26/2020 12:07 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/26/2020	Time: 12:07 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	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 number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(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 RICHLAND MEMORIAL HOSPITAL (14-0147) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
	1.00	2.00	3.00	4.00	5.00		
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-3,441	-29,455	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
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		281,198		0	10.00
10.01	RURAL HEALTH CLINIC II	0		175,207		0	10.01
10.02	RURAL HEALTH CLINIC III	0		53,981		0	10.02
200.00	Total	0	-3,441	480,931	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: 14-0147		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 12:07 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 800 EAST LOCUST			PO Box:				1.00		
2.00	City: OLNEY			State: IL		Zip Code: 62450-2958		County: RICHLAND		
		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		RICHLAND MEMORIAL HOSPITAL	140147	99914	1	07/01/1966	N	P	P
4.00	Subprovider - IPF		RICHLAND MEMORIAL HOSPITAL PSYCH	14S147	99914	4	07/01/1966	N	P	P
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		RICHLAND MEMORIAL HOSPITAL SWING BED	14U147	99914		11/13/2003	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		RICHLAND MEMORIAL HOSPITAL SNF	145580	99914		11/05/1987	N	P	N
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		RICHLAND MEMORIAL HOSPITAL HHA	147187	99914		05/01/1980	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		RICHLAND MEMORIAL HOSPITAL HOSPICE	141542	99914		04/23/1991			
15.00	Hospital-Based Health Clinic - RHC		RICHLAND MEMORIAL HOSPITAL WEST SALE	148548	99914		12/04/2015	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		RICHLAND MEMORIAL HOSPITAL FAM PRAC	148586	99914		03/14/2018	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		RICHLAND MEMORIAL HOSPITAL PRIMARY C	148584	99914		03/15/2018	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
17.20	Hospital-Based (OPT) I									
17.30	Hospital-Based (OOT) I									
17.40	Hospital-Based (OSP) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
8/26/2020 12:07 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.	180	168	0	0	705	25	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					01/01/2019	12/31/2019	36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

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			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	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

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

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			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			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	N		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		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	N		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	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	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 12:07 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				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	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	181,204		0		0118.01	
				1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 12:07 pm	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
				1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
161.10	CORF			N		N	
161.20	OUTPATIENT PHYSICAL THERAPY			N		N	
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N		N	
161.40	OUTPATIENT SPEECH PATHOLOGY			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
				Zip Code		CBSA	
				3.00		4.00	
						FTE/Campus	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						166.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 12:07 pm
			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.			167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99169.00
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0147		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 8/26/2020 12:07 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.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N		Legal Oper.	
				1.00		2.00	
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
						Y/N	
						1.00	
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	03/31/2020	Y	03/31/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	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: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/26/2020 12:07 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				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.	MARGIE	SAUCEDO		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	331-225-0612	MARGARITA.SAUCEDO@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	39	14,235	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)		39	14,235	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	8	2,920	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	43.00				0	13.00
14.00 Total (see instructions)		47	17,155	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	34	12,410		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	1	365			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		82			0	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: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 12:07 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)	2,283	272	3,687		1.00
2.00	HMO and other (see instructions)	226	730			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	2,651	0	3,301		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)	4,934	272	6,988		7.00
8.00	INTENSIVE CARE UNIT	349	42	571		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		34	463		13.00
14.00	Total (see instructions)	5,283	348	8,022	0.00	361.34
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY	0	0	6,825	0.00	15.92
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY	8,488	0	12,372	0.00	12.46
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE	4,623	0	4,845	0.00	5.20
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00
26.00	RURAL HEALTH CLINIC	3,249	0	6,813	0.00	12.35
26.01	RURAL HEALTH CLINIC II	1,619	0	5,773	0.00	7.66
26.02	RURAL HEALTH CLINIC III	1,909	0	13,713	0.00	11.91
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	426.84
28.00	Observation Bed Days		301	1,275		28.00
29.00	Ambulance Trips	1,034				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 12:07 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	759	340	1,891	1.00
2.00 HMO and other (see instructions)			71	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	759	340	1,891	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
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: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/26/2020 12:07 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	28,058,768	0	28,058,768	887,819.75	31.60	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		903,512	0	903,512	7,240.00	124.79	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		962,616	0	962,616	6,024.00	159.80	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	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	834,384	0	834,384	33,122.86	25.19	9.00
10.00	Excluded area salaries (see instructions)		6,547,658	0	6,547,658	175,906.85	37.22	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		461,523	0	461,523	3,788.21	121.83	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		0	0	0	0.00	0.00	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		598,058	0	598,058	11,652.00	51.33	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
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,120,871	0	8,120,871			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,299,659	0	2,299,659			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		189,555	0	189,555			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		188,631	0	188,631			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		145,716	0	145,716			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part II
Date/Time Prepared:
8/26/2020 12:07 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	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	166,018	0	166,018	4,993.47	33.25	26.00
27.00	Administrative & General	5.00	2,990,800	0	2,990,800	94,756.14	31.56	27.00
28.00	Administrative & General under contract (see inst.)		197,023	0	197,023	1,486.00	132.59	28.00
29.00	Maintenance & Repairs	6.00	717,883	0	717,883	29,827.08	24.07	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	247,814	0	247,814	14,834.02	16.71	31.00
32.00	Housekeeping	9.00	447,667	0	447,667	33,267.32	13.46	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	517,047	-392,969	124,078	8,554.58	14.50	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	392,969	392,969	28,971.44	13.56	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,339,984	0	1,339,984	34,149.50	39.24	38.00
39.00	Central Services and Supply	14.00	81,674	0	81,674	5,109.46	15.98	39.00
40.00	Pharmacy	15.00	583,141	0	583,141	13,029.62	44.76	40.00
41.00	Medical Records & Medical Records Library	16.00	493,108	0	493,108	20,862.38	23.64	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part III
Date/Time Prepared:
8/26/2020 12:07 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)	26,389,663	0	26,389,663	876,041.75	30.12	1.00
2.00	Excluded area salaries (see instructions)	7,382,042	0	7,382,042	209,029.71	35.32	2.00
3.00	Subtotal salaries (line 1 minus line 2)	19,007,621	0	19,007,621	667,012.04	28.50	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,059,581	0	1,059,581	15,440.21	68.62	4.00
5.00	Subtotal wage-related costs (see inst.)	8,266,587	0	8,266,587	0.00	43.49	5.00
6.00	Total (sum of lines 3 thru 5)	28,333,789	0	28,333,789	682,452.25	41.52	6.00
7.00	Total overhead cost (see instructions)	7,782,159	0	7,782,159	289,841.01	26.85	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Prepared: 8/26/2020 12:07 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,278,015	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)		6,765,401	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		238,796	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		355,740	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		1,906,093	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		18,882	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		235,790	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		10,798,717	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part V
Date/Time Prepared:
8/26/2020 12:07 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	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	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	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0147 Component CCN: 14-7187		Period: From 01/01/2019 To 12/31/2019		Worksheet S-4 Date/Time Prepared: 8/26/2020 12:07 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	7,540	0	129	7,669	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	361.00	61.00	43.00	465.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.50	0.00	1.50	4.00
5.00	Other Administrative Personnel			0.71	0.00	0.71	5.00
6.00	Direct Nursing Service			6.78	0.00	6.78	6.00
7.00	Nursing Supervisor			0.91	0.00	0.91	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			2.57	0.00	2.57	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,753	1,223	86	110	4,172	21.00
22.00	Skilled Nursing Visit Charges	777,557	345,424	24,290	19,488	1,166,759	22.00
23.00	Physical Therapy Visits	2,229	213	45	61	2,548	23.00
24.00	Physical Therapy Visit Charges	631,498	57,512	12,182	17,282	718,474	24.00
25.00	Occupational Therapy Visits	505	70	4	6	585	25.00
26.00	Occupational Therapy Visit Charges	141,220	19,771	1,130	1,695	163,816	26.00
27.00	Speech Pathology Visits	158	23	9	0	190	27.00
28.00	Speech Pathology Visit Charges	42,648	6,496	2,542	0	51,686	28.00
29.00	Medical Social Service Visits	25	15	0	0	40	29.00
30.00	Medical Social Service Visit Charges	9,809	5,885	0	0	15,694	30.00
31.00	Home Health Aide Visits	677	270	1	5	953	31.00
32.00	Home Health Aide Visit Charges	111,319	44,396	164	0	155,879	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	6,347	1,814	145	182	8,488	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,714,051	479,484	40,308	38,465	2,272,308	35.00
36.00	Total Number of Episodes (standard/non outlier)	384		53	15	452	36.00
37.00	Total Number of Outlier Episodes		38		1	39	37.00
38.00	Total Non-Routine Medical Supply Charges	91,703	56,413	3,623	911	152,650	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-8548		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 8/26/2020 12:07 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			100 SOUTH MAIN			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			WEST SALEM		ILLINOIS 62476		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	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County							2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			17:00		08:00		17:00	
				08:00		17:00		11.00	

Health Financial Systems		RICHLAND MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0147	Period: From 01/01/2019	Worksheet S-8
			Component CCN: 14-8548	To 12/31/2019	Date/Time Prepared: 8/26/2020 12:07 pm
			RHC I		Cost
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-8586		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 8/26/2020 12:07 pm	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			800 LOCUST ST			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			OLNEY IL 62450			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								11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N			0		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.								13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		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			RICHLAND					2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC								11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0147 Component CCN: 14-8586		Period: From 01/01/2019 To 12/31/2019	Worksheet S-8 Date/Time Prepared: 8/26/2020 12:07 pm
					RHC II	Cost
			Friday		Saturday	
			from	to	from	to
			11.00	12.00	13.00	14.00
Facility hours of operations (1)						
11.00	CLINIC					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0147 Component CCN: 14-8584		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 8/26/2020 12:07 pm	
				RHC III		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				800 LOCUST ST				1.00
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				OLNEY IL 62450				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	
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								11.00
								1.00	
								2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		0		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.								13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		XVIII	
				1.00		2.00		3.00	
								XIX	
								Total Visits	
								5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				RICHLAND				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC								11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0147 Component CCN: 14-8584	Period: From 01/01/2019 To 12/31/2019	Worksheet S-8 Date/Time Prepared: 8/26/2020 12:07 pm
			RHC III		Cost
			Friday		Saturday
			from	to	from
			11.00	12.00	13.00
Facility hours of operations (1)					14.00
11.00	CLINIC				11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA				Provider CCN: 14-0147 Hospice CCN: 14-1542		Period: From 01/01/2019 To 12/31/2019		Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 8/26/2020 12:07 pm	
						Hospice I			
		Unduplicated Days							
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)		
		1.00	2.00	3.00	4.00	5.00	6.00		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015									
1.00	Hospice Continuous Home Care							1.00	
2.00	Hospice Routine Home Care							2.00	
3.00	Hospice Inpatient Respite Care							3.00	
4.00	Hospice General Inpatient Care							4.00	
5.00	Total Hospice Days							5.00	
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015									
6.00	Number of patients receiving hospice care							6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00	
8.00	Average Length of Stay (line 5 / line 6)							8.00	
9.00	Unduplicated census count							9.00	
NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.									
				Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)		
				1.00	2.00	3.00	4.00		
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015									
10.00	Hospice Continuous Home Care			0	0	0		10.00	
11.00	Hospice Routine Home Care			5,331	260	272	5,863	11.00	
12.00	Hospice Inpatient Respite Care			0	0	20	20	12.00	
13.00	Hospice General Inpatient Care			31	0	0	31	13.00	
14.00	Total Hospice Days			5,362	260	292	5,914	14.00	
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015									
15.00	Hospice Inpatient Respite Care			0	0	0	0	15.00	
16.00	Hospice General Inpatient Care			0	0	0	0	16.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/26/2020 12:07 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)		0.281183	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,584,061	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		41,939,488	6.00
7.00	Medicaid cost (line 1 times line 6)		11,792,671	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)		7,208,610	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)		7,208,610	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)	0	0	0 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	0	0 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)	0	0	0 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)		1,549,890	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		164,422	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		252,956	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,296,934	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		453,210	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		453,210	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,661,820	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
8/26/2020 12:07 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		613,285	613,285	315,695	928,980	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,872,292	1,872,292	4,488	1,876,780	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	166,018	10,983,182	11,149,200	0	11,149,200	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,990,800	7,605,291	10,596,091	-319,270	10,276,821	5.00
6.00	00600	MAINTENANCE & REPAIRS	717,883	500,249	1,218,132	0	1,218,132	6.00
7.00	00700	OPERATION OF PLANT	0	658,031	658,031	0	658,031	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	247,814	98,570	346,384	0	346,384	8.00
9.00	00900	HOUSEKEEPING	447,667	175,851	623,518	0	623,518	9.00
10.00	01000	DIETARY	517,047	896,432	1,413,479	-1,032,815	380,664	10.00
11.00	01100	CAFETERIA	0	0	0	1,032,815	1,032,815	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,339,984	237,486	1,577,470	0	1,577,470	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	81,674	366,100	447,774	0	447,774	14.00
15.00	01500	PHARMACY	583,141	2,430,860	3,014,001	-1,852,862	1,161,139	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	493,108	129,932	623,040	0	623,040	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,604,382	214,954	2,819,336	0	2,819,336	30.00
31.00	03100	INTENSIVE CARE UNIT	762,886	50,794	813,680	0	813,680	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	269,576	15,841	285,417	0	285,417	43.00
44.00	04400	SKILLED NURSING FACILITY	834,384	152,282	986,666	0	986,666	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	764,535	1,564,770	2,329,305	-67,966	2,261,339	50.00
53.00	05300	ANESTHESIOLOGY	903,512	86,319	989,831	0	989,831	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	688,001	321,742	1,009,743	0	1,009,743	54.00
56.00	05600	RADIOISOTOPE	73,139	178,502	251,641	-140,633	111,008	56.00
57.00	05700	CT SCAN	94,747	231,003	325,750	0	325,750	57.00
58.00	05800	MRI	48,038	123,680	171,718	0	171,718	58.00
60.00	06000	LABORATORY	1,091,239	1,362,747	2,453,986	0	2,453,986	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	33,258	33,258	0	33,258	64.00
65.00	06500	RESPIRATORY THERAPY	453,292	76,506	529,798	-22,064	507,734	65.00
66.00	06600	PHYSICAL THERAPY	1,953,070	95,302	2,048,372	-1,536	2,046,836	66.00
68.00	06800	SPEECH PATHOLOGY	235,496	170,485	405,981	0	405,981	68.00
69.00	06900	ELECTROCARDIOLOGY	0	123,458	123,458	0	123,458	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	164,233	164,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	67,966	67,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,852,862	1,852,862	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	913,034	153,617	1,066,651	0	1,066,651	88.00
88.01	08801	RURAL HEALTH CLINIC II	597,009	592,255	1,189,264	0	1,189,264	88.01
88.02	08802	RURAL HEALTH CLINIC III	716,187	576,974	1,293,161	0	1,293,161	88.02
91.00	09100	EMERGENCY	923,447	2,147,346	3,070,793	0	3,070,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,393,487	213,927	1,607,414	-913	1,606,501	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	830,815	218,111	1,048,926	0	1,048,926	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	312,112	404,072	716,184	0	716,184	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,047,524	35,675,506	59,723,030	0	59,723,030	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,005,343	2,480,292	6,485,635	0	6,485,635	192.00
194.00	07950	OTHER NONREIMBURSABLE	5,901	379	6,280	0	6,280	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	28,058,768	38,156,177	66,214,945	0	66,214,945	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
8/26/2020 12:07 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	-99,993	828,987	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,876,780	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-88,061	11,061,139	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	381,783	10,658,604	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,218,132	6.00
7.00	00700	OPERATION OF PLANT	0	658,031	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-127,000	219,384	8.00
9.00	00900	HOUSEKEEPING	0	623,518	9.00
10.00	01000	DIETARY	0	380,664	10.00
11.00	01100	CAFETERIA	-265,981	766,834	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,577,470	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	447,774	14.00
15.00	01500	PHARMACY	0	1,161,139	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,329	621,711	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-13,655	2,805,681	30.00
31.00	03100	INTENSIVE CARE UNIT	0	813,680	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	285,417	43.00
44.00	04400	SKILLED NURSING FACILITY	-34,224	952,442	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,261,339	50.00
53.00	05300	ANESTHESIOLOGY	-903,512	86,319	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,009,743	54.00
56.00	05600	RADIOISOTOPE	0	111,008	56.00
57.00	05700	CT SCAN	0	325,750	57.00
58.00	05800	MRI	0	171,718	58.00
60.00	06000	LABORATORY	-97,214	2,356,772	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	33,258	64.00
65.00	06500	RESPIRATORY THERAPY	0	507,734	65.00
66.00	06600	PHYSICAL THERAPY	0	2,046,836	66.00
68.00	06800	SPEECH PATHOLOGY	0	405,981	68.00
69.00	06900	ELECTROCARDIOLOGY	0	123,458	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	164,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,852,862	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,066,651	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,189,264	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,293,161	88.02
91.00	09100	EMERGENCY	-2,016,540	1,054,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	1,606,501	95.00
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	1,048,926	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	716,184	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,265,726	56,457,304	118.00
NONREIMBURSABLE COST CENTERS					
192.00	019200	PHYSICIANS' PRIVATE OFFICES	-2,900	6,482,735	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	6,280	194.00
194.01	07952	MEMORY DISORDER	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,268,626	62,946,319	200.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - RECLASS CAFETERIA					1.00
	CAFETERIA	11.00	392,969	639,846		
			392,969	639,846		
1.00	B - INTEREST EXPENSE					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	242,996		
			0	242,996		
1.00	C - OTHER CAPITAL RELATED					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	72,699		
			0	3,575		
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0		2.00	
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	913	3.00	
			0	77,187		
1.00	D - RECLASS IMPLANTS					1.00
	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	67,966		
			0	67,966		
1.00	E - RECLASS MEDICAL SUPPLIES					1.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	140,633		
			0	22,064		
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0		2.00	
3.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,536	3.00	
			0	164,233		
1.00	F - RECLASS DRUGS					1.00
	DRUGS CHARGED TO PATIENTS	73.00	0	1,852,862		
			0	1,852,862		
500.00	Grand Total: Increases		392,969	3,045,090	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
8/26/2020 12:07 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RECLASS CAFETERIA						1.00
	DIETARY	10.00	392,969	639,846	0		
	0		392,969	639,846			
1.00	B - INTEREST EXPENSE						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	242,996	11		
	0		0	242,996			
1.00	C - OTHER CAPITAL RELATED						1.00
	ADMINISTRATIVE & GENERAL	5.00	0	72,699	12		
	2.00	ADMINISTRATIVE & GENERAL	5.00	0	3,575	12	
3.00	AMBULANCE SERVICES	95.00	0	913	12		3.00
	0		0	77,187			
	D - RECLASS IMPLANTS						
1.00	OPERATING ROOM	50.00	0	67,966	0		1.00
	0		0	67,966			
	E - RECLASS MEDICAL SUPPLIES						
1.00	RADIOISOTOPE	56.00	0	140,633	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	22,064	0		2.00
3.00	PHYSICAL THERAPY	66.00	0	1,536	0		3.00
	0		0	164,233			
	F - RECLASS DRUGS						
1.00	PHARMACY	15.00	0	1,852,862	0		1.00
	0		0	1,852,862			
	500.00	Grand Total: Decreases		392,969	3,045,090		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/26/2020 12:07 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	447,600	557,519	0	557,519	0	1.00
2.00	Land Improvements	487,119	1	0	1	0	2.00
3.00	Buildings and Fixtures	17,121,723	2,851,867	0	2,851,867	0	3.00
4.00	Building Improvements	9,558,256	0	0	0	0	4.00
5.00	Fixed Equipment	2,355,173	0	0	0	0	5.00
6.00	Movable Equipment	22,435,686	1,142,816	0	1,142,816	0	6.00
7.00	HIT designated Assets	1,383,128	0	0	0	593,550	7.00
8.00	Subtotal (sum of lines 1-7)	53,788,685	4,552,203	0	4,552,203	593,550	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	53,788,685	4,552,203	0	4,552,203	593,550	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,005,119	0				1.00
2.00	Land Improvements	487,120	0				2.00
3.00	Buildings and Fixtures	19,973,590	0				3.00
4.00	Building Improvements	9,558,256	0				4.00
5.00	Fixed Equipment	2,355,173	0				5.00
6.00	Movable Equipment	23,578,502	0				6.00
7.00	HIT designated Assets	789,578	0				7.00
8.00	Subtotal (sum of lines 1-7)	57,747,338	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	57,747,338	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/26/2020 12:07 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	613,285	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,872,292	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,485,577	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	613,285				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,872,292				2.00
3.00	Total (sum of lines 1-2)	0	2,485,577				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/26/2020 12:07 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	31,887,019	0	31,887,019	0.566829	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,368,080	0	24,368,080	0.433171	0	2.00
3.00	Total (sum of lines 1-2)	56,255,099	0	56,255,099	1.000000	0	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	0	613,285	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,872,292	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,485,577	0	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	143,003	72,699	0	0	828,987	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,488	0	0	1,876,780	2.00
3.00	Total (sum of lines 1-2)	143,003	77,187	0	0	2,705,767	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
8/26/2020 12:07 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)	A	-99,993	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	0	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	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,159,092			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	3,111,870			0	12.00
13.00	Laundry and linen service	B	-127,000	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-219,335	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	0	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,329	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	-20,506	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
8/26/2020 12:07 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 #		
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	SPECIAL FUNCTIONS	B	-26,140	CAFETERIA	11.00	0	33.00
34.00	GUEST ROOM	B	0	ADULTS & PEDIATRICS	30.00	0	34.00
36.00	RETURNED CHECKS	B	0	ADMINISTRATIVE & GENERAL	5.00	0	36.00
38.00	PHYSICIAN RECRUITMENT	A	-126,352	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	CRNA SALARIES	A	-903,512	ANESTHESIOLOGY	53.00	0	39.00
41.00	CRNA BENEFITS	A	-88,061	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	LOBBYING DUES	A	-15,053	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	FOUNDATION SALARIES	A	0	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	FOUNDATION BENEFITS	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	FOUNDATION OTHER	A	0	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	ADVERTISING	A	-362,115	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	PROVIDER TAX ASSESSMENT	A	-2,171,327	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.02	MISC REVENUE	A	-34,224	SKILLED NURSING FACILITY	44.00	0	49.02
49.03	INTEREST RECEIPTS	B	-23,557	ADMINISTRATIVE & GENERAL	5.00	0	49.03
49.04	HOSPITALIST	B	-2,900	PHYSICIANS' PRIVATE OFFICES	192.00	0	49.04
49.05	MISC REVENUE	A	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	49.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,268,626				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
8/26/2020 12:07 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	3,111,870	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,111,870	0	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	
				Name	Percentage of Ownership	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	B	THE CARLE FOUND	100.00	SYSTEM	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
8/26/2020 12:07 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	3,111,870	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	3,111,870			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-2

Date/Time Prepared:
8/26/2020 12:07 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	5.00	ADMINISTRATIVE & GENERAL	31,683	31,683	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	13,655	13,655	0	211,500	0	2.00
3.00	60.00	LABORATORY	97,214	97,214	0	260,300	0	3.00
4.00	91.00	EMERGENCY	2,016,540	2,016,540	0	211,500	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,159,092	2,159,092	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	31,683		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	13,655		2.00
3.00	60.00	LABORATORY	0	0	0	97,214		3.00
4.00	91.00	EMERGENCY	0	0	0	2,016,540		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,159,092		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 12:07 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	828,987	828,987			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,876,780		1,876,780		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,061,139	2,648	0	11,063,787	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,658,604	80,317	340,614	1,186,316	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,218,132	10,958	176,924	284,752	6.00
7.00	00700	OPERATION OF PLANT	658,031	38,113	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	219,384	15,717	12,818	98,297	8.00
9.00	00900	HOUSEKEEPING	623,518	1,787	3,830	177,569	9.00
10.00	01000	DIETARY	380,664	32,972	17,240	49,216	10.00
11.00	01100	CAFETERIA	766,834	9,354	0	155,873	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,577,470	32,704	200,302	531,511	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	447,774	23,167	30,646	32,396	14.00
15.00	01500	PHARMACY	1,161,139	12,529	57,231	231,306	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	621,711	9,735	3,467	195,594	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,805,681	130,795	42,586	1,033,041	30.00
31.00	03100	INTENSIVE CARE UNIT	813,680	30,485	12,744	302,603	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	200	0	40.00
43.00	04300	NURSERY	285,417	4,308	4,007	106,929	43.00
44.00	04400	SKILLED NURSING FACILITY	952,442	15,614	11,247	330,963	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,261,339	50,801	148,330	303,257	50.00
53.00	05300	ANESTHESIOLOGY	86,319	0	51,855	358,383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,009,743	36,725	201,409	272,899	54.00
56.00	05600	RADIOISOTOPE	111,008	4,233	23,526	29,011	56.00
57.00	05700	CT SCAN	325,750	3,259	20,596	37,582	57.00
58.00	05800	MRI	171,718	0	254,481	19,055	58.00
60.00	06000	LABORATORY	2,356,772	34,322	76,079	432,845	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	33,258	301	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	507,734	3,950	11,336	179,801	65.00
66.00	06600	PHYSICAL THERAPY	2,046,836	25,081	21,345	774,695	66.00
68.00	06800	SPEECH PATHOLOGY	405,981	974	2,474	93,411	68.00
69.00	06900	ELECTROCARDIOLOGY	123,458	1,693	9,808	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,233	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,966	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,852,862	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,066,651	14,109	15,066	362,160	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,189,264	14,692	0	236,807	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,293,161	12,152	0	284,079	88.02
91.00	09100	EMERGENCY	1,054,253	16,047	29,491	366,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,606,501	23,280	70,358	552,734	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,048,926	6,269	74	329,547	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	716,184	6,269	833	123,801	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,457,304	705,360	1,850,917	9,472,723	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,482,735	122,931	25,863	1,588,723	192.00
194.00	07950	OTHER NONREIMBURSABLE	6,280	0	0	2,341	194.00
194.01	07952	MEMORY DISORDER	0	696	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						0 200.00
201.00		Negative Cost Centers		0	0	0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	62,946,319	828,987	1,876,780	11,063,787	62,946,319	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 12:07 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	12,265,851					5.00
6.00	00600	MAINTENANCE & REPAIRS	409,204	2,099,970				6.00
7.00	00700	OPERATION OF PLANT	168,483	108,883	973,510			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	83,792	44,902	21,954	496,864		8.00
9.00	00900	HOUSEKEEPING	195,241	5,106	2,496	32,731	1,042,278	9.00
10.00	01000	DIETARY	116,193	94,198	46,056	1,611	0	10.00
11.00	01100	CAFETERIA	225,580	26,724	13,066	6,061	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	566,815	93,432	45,682	0	22,569	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	129,236	66,184	32,360	7,156	14,020	14.00
15.00	01500	PHARMACY	353,887	35,793	17,500	0	6,155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	201,002	27,812	13,598	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	971,021	373,658	182,697	131,987	268,777	30.00
31.00	03100	INTENSIVE CARE UNIT	280,629	87,090	42,581	45,478	45,993	31.00
40.00	04000	SUBPROVIDER - IPF	48	0	0	0	0	40.00
43.00	04300	NURSERY	96,969	12,307	6,017	31,197	28,724	43.00
44.00	04400	SKILLED NURSING FACILITY	317,115	44,606	21,810	137,519	87,540	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	668,885	145,132	70,960	48,247	65,655	50.00
53.00	05300	ANESTHESIOLOGY	120,178	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	368,063	104,919	51,299	9,099	45,138	54.00
56.00	05600	RADIOISOTOPE	40,606	12,092	5,912	1,019	10,772	56.00
57.00	05700	CT SCAN	93,708	9,311	4,552	0	11,285	57.00
58.00	05800	MRI	107,762	0	0	0	0	58.00
60.00	06000	LABORATORY	701,871	98,054	47,942	1,540	28,724	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	8,122	860	420	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	170,099	11,286	5,518	0	4,103	65.00
66.00	06600	PHYSICAL THERAPY	694,112	71,652	35,033	7,935	120,881	66.00
68.00	06800	SPEECH PATHOLOGY	121,699	2,781	1,360	0	14,362	68.00
69.00	06900	ELECTROCARDIOLOGY	32,663	4,837	2,365	0	15,388	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,748	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,449	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	448,435	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	352,866	40,307	19,707	508	39,838	88.00
88.01	08801	RURAL HEALTH CLINIC II	348,698	41,973	20,522	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	384,669	34,718	16,975	0	0	88.02
91.00	09100	EMERGENCY	354,825	45,843	22,414	31,707	100,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	545,247	66,507	32,517	3,069	2,565	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	335,157	17,910	8,757	0	26,672	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	205,015	17,910	8,757	0	26,672	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,274,092	1,746,787	800,827	496,864	986,368	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,989,505	351,195	171,711	0	55,910	192.00
194.00	07950	OTHER NONREIMBURSABLE	2,086	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	168	1,988	972	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
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)	12,265,851	2,099,970	973,510	496,864	1,042,278	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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	738,150					10.00
11.00	01100	CAFETERIA	0	1,203,492				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	158,499	0	3,228,984		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,420	0	0	811,359	14.00
15.00	01500	PHARMACY	0	36,072	0	0	10,629	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	88,540	0	0	6,422	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	245,562	118,054	0	851,441	29,900	30.00
31.00	03100	INTENSIVE CARE UNIT	38,030	38,258	0	266,433	6,286	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	112,977	3,567	43.00
44.00	04400	SKILLED NURSING FACILITY	454,558	104,937	0	812,792	5,974	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	108,216	0	264,146	290,092	50.00
53.00	05300	ANESTHESIOLOGY	0	5,465	0	92,394	12,407	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	50,282	0	0	5,489	54.00
56.00	05600	RADIOISOTOPE	0	4,372	0	0	34,457	56.00
57.00	05700	CT SCAN	0	12,024	0	0	16,052	57.00
58.00	05800	MRI	0	0	0	0	2,571	58.00
60.00	06000	LABORATORY	0	44,817	0	0	147,725	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	72,144	0	0	13,087	65.00
66.00	06600	PHYSICAL THERAPY	0	111,495	0	0	17,748	66.00
68.00	06800	SPEECH PATHOLOGY	0	5,465	0	0	38,677	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	954	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	7,984	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	10,830	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	9,245	88.02
91.00	09100	EMERGENCY	0	21,862	0	353,567	20,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	72,144	0	475,234	23,416	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	16,396	0	0	16,990	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	13,117	0	0	26,532	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	738,150	1,110,579	0	3,228,984	757,305	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	92,913	0	0	54,054	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
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)	738,150	1,203,492	0	3,228,984	811,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,922,241					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,167,881				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	251,947	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,371	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	18,371	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	23,620	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	364,800	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,869	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	57,738	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	522,889	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	524,162	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	246,388	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	126,062	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	123,349	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,419,501	887,065	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	502,740	280,816	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,922,241	1,167,881	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	7,437,147	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	2,028,661	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	248	0	40.00
43.00	04300	NURSERY	0	0	0	710,790	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,320,737	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,789,860	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	727,001	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	2,183,934	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	277,008	0	56.00
57.00	05700	CT SCAN	0	0	0	534,119	0	57.00
58.00	05800	MRI	0	0	0	555,587	0	58.00
60.00	06000	LABORATORY	0	0	0	4,028,429	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	565,850	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	979,058	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,926,813	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	687,184	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	191,166	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	203,981	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	84,415	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,301,297	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,443,358	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,109,174	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,161,061	0	88.02
91.00	09100	EMERGENCY	0	0	0	2,540,454	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	3,473,572	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,806,698	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE			0	1,145,090	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	51,212,692	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	11,719,096	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	10,707	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	3,824	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV				
			21.00	22.00				
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	62,946,319	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description		Total	
		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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE	194.00
194.01	07952	MEMORY DISORDER	194.01
194.02	07953	ASSISTED LIVING	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,648	0	2,648	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,968	80,317	340,614	424,899	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	10,958	176,924	187,882	6.00
7.00	00700	OPERATION OF PLANT	0	38,113	0	38,113	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,717	12,818	28,535	8.00
9.00	00900	HOUSEKEEPING	0	1,787	3,830	5,617	9.00
10.00	01000	DIETARY	0	32,972	17,240	50,212	10.00
11.00	01100	CAFETERIA	0	9,354	0	9,354	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	32,704	200,302	233,006	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,167	30,646	53,813	14.00
15.00	01500	PHARMACY	0	12,529	57,231	69,760	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,735	3,467	13,202	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,403	130,795	42,586	186,784	30.00
31.00	03100	INTENSIVE CARE UNIT	1,107	30,485	12,744	44,336	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	200	200	40.00
43.00	04300	NURSERY	0	4,308	4,007	8,315	43.00
44.00	04400	SKILLED NURSING FACILITY	0	15,614	11,247	26,861	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,152	50,801	148,330	205,283	50.00
53.00	05300	ANESTHESIOLOGY	0	0	51,855	51,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,725	201,409	238,134	54.00
56.00	05600	RADIOISOTOPE	0	4,233	23,526	27,759	56.00
57.00	05700	CT SCAN	0	3,259	20,596	23,855	57.00
58.00	05800	MRI	0	0	254,481	254,481	58.00
60.00	06000	LABORATORY	0	34,322	76,079	110,401	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	301	0	301	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,950	11,336	15,286	65.00
66.00	06600	PHYSICAL THERAPY	0	25,081	21,345	46,426	66.00
68.00	06800	SPEECH PATHOLOGY	0	974	2,474	3,448	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,693	9,808	11,501	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	14,109	15,066	29,175	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	14,692	0	14,692	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	12,152	0	12,152	88.02
91.00	09100	EMERGENCY	0	16,047	29,491	45,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,413	23,280	70,358	97,051	95.00
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	25,090	6,269	74	31,433	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	87,475	6,269	833	94,577	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,608	705,360	1,850,917	2,696,885	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	122,931	25,863	148,794	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	696	0	696	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	194.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	140,608	828,987	1,876,780	2,846,375	2,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			ADMINISTRATIVE E & 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	425,183					5.00
6.00	00600	MAINTENANCE & REPAIRS	14,184	202,134				6.00
7.00	00700	OPERATION OF PLANT	5,840	10,481	54,434			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,904	4,322	1,228	37,013		8.00
9.00	00900	HOUSEKEEPING	6,767	491	140	2,438	15,496	9.00
10.00	01000	DIETARY	4,027	9,067	2,575	120	0	10.00
11.00	01100	CAFETERIA	7,819	2,572	731	452	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	19,647	8,993	2,554	0	336	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,480	6,371	1,809	533	208	14.00
15.00	01500	PHARMACY	12,266	3,445	979	0	92	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,967	2,677	760	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	33,658	35,965	10,215	9,832	3,994	30.00
31.00	03100	INTENSIVE CARE UNIT	9,727	8,383	2,381	3,388	684	31.00
40.00	04000	SUBPROVIDER - IPF	2	0	0	0	0	40.00
43.00	04300	NURSERY	3,361	1,185	336	2,324	427	43.00
44.00	04400	SKILLED NURSING FACILITY	10,992	4,294	1,219	10,243	1,302	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,185	13,970	3,968	3,594	976	50.00
53.00	05300	ANESTHESIOLOGY	4,166	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,758	10,099	2,868	678	671	54.00
56.00	05600	RADIOISOTOPE	1,407	1,164	331	76	160	56.00
57.00	05700	CT SCAN	3,248	896	255	0	168	57.00
58.00	05800	MRI	3,735	0	0	0	0	58.00
60.00	06000	LABORATORY	24,328	9,438	2,681	115	427	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	282	83	24	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,896	1,086	309	0	61	65.00
66.00	06600	PHYSICAL THERAPY	24,059	6,897	1,959	591	1,797	66.00
68.00	06800	SPEECH PATHOLOGY	4,218	268	76	0	214	68.00
69.00	06900	ELECTROCARDIOLOGY	1,132	466	132	0	229	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,378	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	570	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,544	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	12,231	3,880	1,102	38	592	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,087	4,040	1,147	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	13,333	3,342	949	0	0	88.02
91.00	09100	EMERGENCY	12,299	4,413	1,253	2,362	1,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	18,899	6,402	1,818	229	38	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	11,617	1,724	490	0	397	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	7,106	1,724	490	0	397	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	356,119	168,138	44,779	37,013	14,665	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	68,986	33,805	9,601	0	831	192.00
194.00	07950	OTHER NONREIMBURSABLE	72	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	6	191	54	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
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)	425,183	202,134	54,434	37,013	15,496	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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	66,013					10.00
11.00	01100	CAFETERIA	0	20,965				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	2,761	0	267,424		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	495	0	0	67,717	14.00
15.00	01500	PHARMACY	0	628	0	0	887	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,542	0	0	536	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,961	2,057	0	70,516	2,495	30.00
31.00	03100	INTENSIVE CARE UNIT	3,401	666	0	22,066	525	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	9,357	298	43.00
44.00	04400	SKILLED NURSING FACILITY	40,651	1,828	0	67,315	499	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,885	0	21,877	24,212	50.00
53.00	05300	ANESTHESIOLOGY	0	95	0	7,652	1,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	876	0	0	458	54.00
56.00	05600	RADIOISOTOPE	0	76	0	0	2,876	56.00
57.00	05700	CT SCAN	0	209	0	0	1,340	57.00
58.00	05800	MRI	0	0	0	0	215	58.00
60.00	06000	LABORATORY	0	781	0	0	12,329	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,257	0	0	1,092	65.00
66.00	06600	PHYSICAL THERAPY	0	1,942	0	0	1,481	66.00
68.00	06800	SPEECH PATHOLOGY	0	95	0	0	3,228	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	80	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	666	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	904	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	772	88.02
91.00	09100	EMERGENCY	0	381	0	29,282	1,692	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,257	0	39,359	1,954	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	286	0	0	1,418	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	229	0	0	2,214	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,013	19,346	0	267,424	63,206	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,619	0	0	4,511	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
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)	66,013	20,965	0	267,424	67,717	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	88,112					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,731				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	5,551	0			30.00
31.00	03100	INTENSIVE CARE UNIT	0	405	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0			40.00
43.00	04300	NURSERY	0	405	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	520	0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	8,037	0			50.00
53.00	05300	ANESTHESIOLOGY	0	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	636	0			54.00
56.00	05600	RADIOISOTOPE	0	0	0			56.00
57.00	05700	CT SCAN	0	0	0			57.00
58.00	05800	MRI	0	0	0			58.00
60.00	06000	LABORATORY	0	1,272	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	23,968	0	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0			73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	24,027	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	11,294	0	0			88.01
88.02	08802	RURAL HEALTH CLINIC III	5,778	0	0			88.02
91.00	09100	EMERGENCY	0	2,718	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0			95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,067	19,544	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,045	6,187	0			192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0			194.00
194.01	07952	MEMORY DISORDER	0	0	0			194.01
194.02	07953	ASSISTED LIVING	0	0	0			194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	88,112	25,731	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				383,275	0	30.00
31.00	03100	INTENSIVE CARE UNIT				96,034	0	31.00
40.00	04000	SUBPROVIDER - IPF				202	0	40.00
43.00	04300	NURSERY				26,034	0	43.00
44.00	04400	SKILLED NURSING FACILITY				165,803	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				307,060	0	50.00
53.00	05300	ANESTHESIOLOGY				64,889	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				267,243	0	54.00
56.00	05600	RADIOISOTOPE				33,856	0	56.00
57.00	05700	CT SCAN				29,980	0	57.00
58.00	05800	MRI				258,436	0	58.00
60.00	06000	LABORATORY				161,876	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				24,658	0	64.00
65.00	06500	RESPIRATORY THERAPY				25,030	0	65.00
66.00	06600	PHYSICAL THERAPY				85,338	0	66.00
68.00	06800	SPEECH PATHOLOGY				11,569	0	68.00
69.00	06900	ELECTROCARDIOLOGY				13,540	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				1,378	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				570	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				15,544	0	73.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				71,798	0	88.00
88.01	08801	RURAL HEALTH CLINIC II				44,221	0	88.01
88.02	08802	RURAL HEALTH CLINIC III				36,394	0	88.02
91.00	09100	EMERGENCY				101,521	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES				167,139	0	95.00
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
101.00	10100	HOME HEALTH AGENCY				47,444	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE				106,767	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	2,547,599	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES				297,756	0	192.00
194.00	07950	OTHER NONREIMBURSABLE				73	0	194.00
194.01	07952	MEMORY DISORDER				947	0	194.01

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV				
			21.00	22.00				
194.02	07953	ASSISTED LIVING				0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	2,846,375	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description		Total	
		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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
88.02	08802	RURAL HEALTH CLINIC III	88.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONREIMBURSABLE	194.00
194.01	07952	MEMORY DISORDER	194.01
194.02	07953	ASSISTED LIVING	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 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 -NEW)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	176,269					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,786,972				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	563	0	27,892,750			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,078	324,315	2,990,800	-12,265,851	50,680,468	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,330	168,458	717,883	0	1,690,766	6.00
7.00	00700	OPERATION OF PLANT	8,104	0	0	0	696,144	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,342	12,205	247,814	0	346,216	8.00
9.00	00900	HOUSEKEEPING	380	3,647	447,667	0	806,704	9.00
10.00	01000	DIETARY	7,011	16,415	124,078	0	480,092	10.00
11.00	01100	CAFETERIA	1,989	0	392,969	0	932,061	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,954	190,717	1,339,984	0	2,341,987	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,926	29,180	81,674	0	533,983	14.00
15.00	01500	PHARMACY	2,664	54,492	583,141	0	1,462,205	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,070	3,301	493,108	0	830,507	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,811	40,548	2,604,382	0	4,012,103	30.00
31.00	03100	INTENSIVE CARE UNIT	6,482	12,134	762,886	0	1,159,512	31.00
40.00	04000	SUBPROVIDER - IPF	0	190	0	0	200	40.00
43.00	04300	NURSERY	916	3,815	269,576	0	400,661	43.00
44.00	04400	SKILLED NURSING FACILITY	3,320	10,709	834,384	0	1,310,266	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,802	141,232	764,535	0	2,763,727	50.00
53.00	05300	ANESTHESIOLOGY	0	49,374	903,512	0	496,557	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,809	191,771	688,001	0	1,520,776	54.00
56.00	05600	RADIOISOTOPE	900	22,400	73,139	0	167,778	56.00
57.00	05700	CT SCAN	693	19,610	94,747	0	387,187	57.00
58.00	05800	MRI	0	242,304	48,038	0	445,254	58.00
60.00	06000	LABORATORY	7,298	72,438	1,091,239	0	2,900,018	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	64	0	0	0	33,559	64.00
65.00	06500	RESPIRATORY THERAPY	840	10,794	453,292	0	702,821	65.00
66.00	06600	PHYSICAL THERAPY	5,333	20,324	1,953,070	0	2,867,957	66.00
68.00	06800	SPEECH PATHOLOGY	207	2,356	235,496	0	502,840	68.00
69.00	06900	ELECTROCARDIOLOGY	360	9,339	0	0	134,959	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	164,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	67,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,852,862	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,000	14,345	913,034	0	1,457,986	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,124	0	597,009	0	1,440,763	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,584	0	716,187	0	1,589,392	88.02
91.00	09100	EMERGENCY	3,412	28,080	923,447	0	1,466,081	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,950	66,991	1,393,487	0	2,252,873	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,333	70	830,815	0	1,384,816	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,333	793	312,112	0	847,087	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	149,982	1,762,347	23,881,506	-12,265,851	42,450,899	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,139	24,625	4,005,343	0	8,220,252	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	5,901	0	8,621	194.00
194.01	07952	MEMORY DISORDER	148	0	0	0	696	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VAL UE -NEW)				
			1.00	2.00	4.00	5A	5.00	
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
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)	828,987	1,876,780	11,063,787		12,265,851	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.702965	1.050257	0.396655		0.242023	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,648		425,183	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000095		0.008389	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: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (DIETARY ME ALS SERV)	
			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	156,298					6.00
7.00	00700	OPERATION OF PLANT	8,104	148,194				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,342	3,342	464,064			8.00
9.00	00900	HOUSEKEEPING	380	380	30,570	6,096		9.00
10.00	01000	DIETARY	7,011	7,011	1,505	0	11,083	10.00
11.00	01100	CAFETERIA	1,989	1,989	5,661	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,954	6,954	0	132	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,926	4,926	6,684	82	0	14.00
15.00	01500	PHARMACY	2,664	2,664	0	36	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,070	2,070	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,811	27,811	123,274	1,572	3,687	30.00
31.00	03100	INTENSIVE CARE UNIT	6,482	6,482	42,476	269	571	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	916	916	29,138	168	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,320	3,320	128,441	512	6,825	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,802	10,802	45,062	384	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,809	7,809	8,498	264	0	54.00
56.00	05600	RADIOISOTOPE	900	900	952	63	0	56.00
57.00	05700	CT SCAN	693	693	0	66	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,298	7,298	1,438	168	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	64	64	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	840	840	0	24	0	65.00
66.00	06600	PHYSICAL THERAPY	5,333	5,333	7,411	707	0	66.00
68.00	06800	SPEECH PATHOLOGY	207	207	0	84	0	68.00
69.00	06900	ELECTROCARDIOLOGY	360	360	0	90	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,000	3,000	474	233	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,124	3,124	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,584	2,584	0	0	0	88.02
91.00	09100	EMERGENCY	3,412	3,412	29,614	588	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,950	4,950	2,866	15	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,333	1,333	0	156	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,333	1,333	0	156	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,011	121,907	464,064	5,769	11,083	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,139	26,139	0	327	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	148	148	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY PO UNDS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (DIETARY ME ALS SERV)	
			6.00	7.00	8.00	9.00	10.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,099,970	973,510	496,864	1,042,278	738,150	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.435681	6.569159	1.070680	170.977362	66.602003	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	202,134	54,434	37,013	15,496	66,013	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.293260	0.367316	0.079758	2.541995	5.956239	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: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:

8/26/2020 12:07 pm

Cost Center Description			CAFETERIA (CAFE MEALS SERV)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NUR SING HO)	CENTRAL SERVICES & SUPPLY (CS COSTED REQUIS)	PHARMACY (PHARM COST ED REQ)	
			11.00	12.00	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						10.00
11.00	01100	CAFETERIA	1,101					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	145	0	14,119			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26	0	0	3,432,019		14.00
15.00	01500	PHARMACY	33	0	0	44,962	122,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	81	0	0	27,164	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	108	0	3,723	126,475	0	30.00
31.00	03100	INTENSIVE CARE UNIT	35	0	1,165	26,591	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	494	15,088	0	43.00
44.00	04400	SKILLED NURSING FACILITY	96	0	3,554	25,270	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	99	0	1,155	1,227,084	0	50.00
53.00	05300	ANESTHESIOLOGY	5	0	404	52,479	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46	0	0	23,220	0	54.00
56.00	05600	RADIOISOTOPE	4	0	0	145,752	0	56.00
57.00	05700	CT SCAN	11	0	0	67,899	0	57.00
58.00	05800	MRI	0	0	0	10,874	0	58.00
60.00	06000	LABORATORY	41	0	0	624,870	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	33,270	64.00
65.00	06500	RESPIRATORY THERAPY	66	0	0	55,357	0	65.00
66.00	06600	PHYSICAL THERAPY	102	0	0	75,073	0	66.00
68.00	06800	SPEECH PATHOLOGY	5	0	0	163,601	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,034	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	33,771	33,351	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	45,812	15,677	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	39,108	8,021	88.02
91.00	09100	EMERGENCY	20	0	1,546	85,746	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	66	0	2,078	99,047	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	15	0	0	71,866	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	12	0	0	112,230	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,016	0	14,119	3,203,373	90,319	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	85	0	0	228,646	31,988	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description		CAFETERIA (CAFE MEALS SERV)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NUR SING HO)	CENTRAL SERVICES & SUPPLY (CS COSTED REQUIS)	PHARMACY (PHARM COST ED REQ)	
		11.00	12.00	13.00	14.00	15.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,203,492	0	3,228,984	811,359	1,922,241	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1,093.089918	0.000000	228.697783	0.236409	15.716525	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	20,965	0	267,424	67,717	88,112	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	19.041780	0.000000	18.940718	0.019731	0.720417	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: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	445					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	96	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	7	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	139	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	22	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	47	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0		0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	338	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	107	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07952	MEMORY DISORDER	0	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
194.02	07953	ASSISTED LIVING	0	0	0	0	0	194.02
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)	1,167,881	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2,624.451685	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,731	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	57.822472	0.000000	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
			22.00			23.00
			GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00	
5.00	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	
12.00	01200	MAINTENANCE OF PERSONNEL			12.00	
13.00	01300	NURSING ADMINISTRATION			13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00	
15.00	01500	PHARMACY			15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00	
17.00	01700	SOCIAL SERVICE			17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00	
20.00	02000	NURSING SCHOOL			20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	40.00	
43.00	04300	NURSERY	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
56.00	05600	RADIOISOTOPE	0	0	56.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MRI	0	0	58.00	
60.00	06000	LABORATORY	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	95.00	
99.10	09910	CORF	0	0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40	
101.00	10100	HOME HEALTH AGENCY	0	0	101.00	
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE		0	116.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00	
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00	
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00	
194.01	07952	MEMORY DISORDER	0	0	194.01	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
194.02	07953	ASSISTED LIVING	0	0	194.02
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)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 12:07 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	7,437,147		7,437,147	0	7,437,147	30.00
31.00	03100	INTENSIVE CARE UNIT	2,028,661		2,028,661	0	2,028,661	31.00
40.00	04000	SUBPROVIDER - IPF	248		248	0	248	40.00
43.00	04300	NURSERY	710,790		710,790	0	710,790	43.00
44.00	04400	SKILLED NURSING FACILITY	3,320,737		3,320,737	0	3,320,737	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,789,860		4,789,860	0	4,789,860	50.00
53.00	05300	ANESTHESIOLOGY	727,001		727,001	0	727,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,183,934		2,183,934	0	2,183,934	54.00
56.00	05600	RADIOISOTOPE	277,008		277,008	0	277,008	56.00
57.00	05700	CT SCAN	534,119		534,119	0	534,119	57.00
58.00	05800	MRI	555,587		555,587	0	555,587	58.00
60.00	06000	LABORATORY	4,028,429		4,028,429	0	4,028,429	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	565,850		565,850	0	565,850	64.00
65.00	06500	RESPIRATORY THERAPY	979,058	0	979,058	0	979,058	65.00
66.00	06600	PHYSICAL THERAPY	3,926,813	0	3,926,813	0	3,926,813	66.00
68.00	06800	SPEECH PATHOLOGY	687,184	0	687,184	0	687,184	68.00
69.00	06900	ELECTROCARDIOLOGY	191,166		191,166	0	191,166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	203,981		203,981	0	203,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,415		84,415	0	84,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,301,297		2,301,297	0	2,301,297	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,443,358		2,443,358	0	2,443,358	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,109,174		2,109,174	0	2,109,174	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,161,061		2,161,061	0	2,161,061	88.02
91.00	09100	EMERGENCY	2,540,454		2,540,454	0	2,540,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,910,996		1,910,996	0	1,910,996	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,473,572		3,473,572	0	3,473,572	95.00
99.10	09910	CORF	0		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,806,698		1,806,698	0	1,806,698	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,145,090		1,145,090	0	1,145,090	116.00
200.00		Subtotal (see instructions)	53,123,688	0	53,123,688	0	53,123,688	200.00
201.00		Less Observation Beds	1,910,996		1,910,996	0	1,910,996	201.00
202.00		Total (see instructions)	51,212,692	0	51,212,692	0	51,212,692	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 12:07 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	9,678,582		9,678,582		30.00
31.00	03100	INTENSIVE CARE UNIT	3,072,152		3,072,152		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
43.00	04300	NURSERY	571,087		571,087		43.00
44.00	04400	SKILLED NURSING FACILITY	1,222,033		1,222,033		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,040,841	16,419,971	19,460,812	0.246128	0.000000
53.00	05300	ANESTHESIOLOGY	742,641	4,019,470	4,762,111	0.152664	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,785,700	11,750,222	13,535,922	0.161344	0.000000
56.00	05600	RADIOISOTOPE	157,925	3,806,903	3,964,828	0.069866	0.000000
57.00	05700	CT SCAN	1,758,717	15,241,677	17,000,394	0.031418	0.000000
58.00	05800	MRI	222,215	3,850,104	4,072,319	0.136430	0.000000
60.00	06000	LABORATORY	3,790,645	25,245,614	29,036,259	0.138738	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	292,262	473,511	765,773	0.738927	0.000000
65.00	06500	RESPIRATORY THERAPY	797,062	528,588	1,325,650	0.738549	0.000000
66.00	06600	PHYSICAL THERAPY	4,041,371	12,205,434	16,246,805	0.241698	0.000000
68.00	06800	SPEECH PATHOLOGY	286,788	1,137,608	1,424,396	0.482439	0.000000
69.00	06900	ELECTROCARDIOLOGY	424,037	2,897,626	3,321,663	0.057551	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,668,285	6,047,836	8,716,121	0.023403	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	442,794	929,242	1,372,036	0.061525	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	4,443,919	6,263,185	10,707,104	0.214932	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,405,388	1,405,388		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,469,665	1,469,665		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	2,323,342	2,323,342		88.02
91.00	09100	EMERGENCY	1,673,713	11,209,552	12,883,265	0.197190	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	753,593	5,957,042	6,710,635	0.284771	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,762,354	2,762,354	1.257468	0.000000
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
101.00	10100	HOME HEALTH AGENCY	0	1,953,359	1,953,359		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	44,566	2,324,405	2,368,971		116.00
200.00		Subtotal (see instructions)	41,910,928	140,222,098	182,133,026		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	41,910,928	140,222,098	182,133,026		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 12:07 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
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.246128			50.00
53.00	05300	ANESTHESIOLOGY	0.152664			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161344			54.00
56.00	05600	RADIOISOTOPE	0.069866			56.00
57.00	05700	CT SCAN	0.031418			57.00
58.00	05800	MRI	0.136430			58.00
60.00	06000	LABORATORY	0.138738			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.738927			64.00
65.00	06500	RESPIRATORY THERAPY	0.738549			65.00
66.00	06600	PHYSICAL THERAPY	0.241698			66.00
68.00	06800	SPEECH PATHOLOGY	0.482439			68.00
69.00	06900	ELECTROCARDIOLOGY	0.057551			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023403			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.061525			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214932			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
91.00	09100	EMERGENCY	0.197190			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284771			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.257468			95.00
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE				116.00
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: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,437,147		7,437,147	0	7,437,147	30.00
31.00	03100	INTENSIVE CARE UNIT	2,028,661		2,028,661	0	2,028,661	31.00
40.00	04000	SUBPROVIDER - IPF	248		248	0	248	40.00
43.00	04300	NURSERY	710,790		710,790	0	710,790	43.00
44.00	04400	SKILLED NURSING FACILITY	3,320,737		3,320,737	0	3,320,737	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,789,860		4,789,860	0	4,789,860	50.00
53.00	05300	ANESTHESIOLOGY	727,001		727,001	0	727,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,183,934		2,183,934	0	2,183,934	54.00
56.00	05600	RADIOISOTOPE	277,008		277,008	0	277,008	56.00
57.00	05700	CT SCAN	534,119		534,119	0	534,119	57.00
58.00	05800	MRI	555,587		555,587	0	555,587	58.00
60.00	06000	LABORATORY	4,028,429		4,028,429	0	4,028,429	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	565,850		565,850	0	565,850	64.00
65.00	06500	RESPIRATORY THERAPY	979,058	0	979,058	0	979,058	65.00
66.00	06600	PHYSICAL THERAPY	3,926,813	0	3,926,813	0	3,926,813	66.00
68.00	06800	SPEECH PATHOLOGY	687,184	0	687,184	0	687,184	68.00
69.00	06900	ELECTROCARDIOLOGY	191,166		191,166	0	191,166	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	203,981		203,981	0	203,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,415		84,415	0	84,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,301,297		2,301,297	0	2,301,297	73.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,443,358		2,443,358	0	2,443,358	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,109,174		2,109,174	0	2,109,174	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,161,061		2,161,061	0	2,161,061	88.02
91.00	09100	EMERGENCY	2,540,454		2,540,454	0	2,540,454	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,910,996		1,910,996	0	1,910,996	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,473,572		3,473,572	0	3,473,572	95.00
99.10	09910	CORF	0		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,806,698		1,806,698	0	1,806,698	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,145,090		1,145,090	0	1,145,090	116.00
200.00		Subtotal (see instructions)	53,123,688	0	53,123,688	0	53,123,688	200.00
201.00		Less Observation Beds	1,910,996		1,910,996	0	1,910,996	201.00
202.00		Total (see instructions)	51,212,692	0	51,212,692	0	51,212,692	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

			Title XIX			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	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
43.00	04300	NURSERY	0		0			43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0.000000	0.000000	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0.000000	0.000000	88.02	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00	
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
	SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			88.02
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE				116.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,789,860	307,060	4,482,800	0	0 50.00
53.00	05300	ANESTHESIOLOGY	727,001	64,889	662,112	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,183,934	267,243	1,916,691	0	0 54.00
56.00	05600	RADIOISOTOPE	277,008	33,856	243,152	0	0 56.00
57.00	05700	CT SCAN	534,119	29,980	504,139	0	0 57.00
58.00	05800	MRI	555,587	258,436	297,151	0	0 58.00
60.00	06000	LABORATORY	4,028,429	161,876	3,866,553	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	565,850	24,658	541,192	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	979,058	25,030	954,028	0	0 65.00
66.00	06600	PHYSICAL THERAPY	3,926,813	85,338	3,841,475	0	0 66.00
68.00	06800	SPEECH PATHOLOGY	687,184	11,569	675,615	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	191,166	13,540	177,626	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	203,981	1,378	202,603	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,415	570	83,845	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,301,297	15,544	2,285,753	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,443,358	71,798	2,371,560	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	2,109,174	44,221	2,064,953	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	2,161,061	36,394	2,124,667	0	0 88.02
91.00	09100	EMERGENCY	2,540,454	101,521	2,438,933	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,910,996	98,483	1,812,513	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,473,572	167,139	3,306,433	0	0 95.00
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
101.00	10100	HOME HEALTH AGENCY	1,806,698	47,444	1,759,254	0	0 101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	1,145,090	106,767	1,038,323	0	0 116.00
200.00		Subtotal (sum of lines 50 thru 199)	39,626,105	1,974,734	37,651,371	0	0 200.00
201.00		Less Observation Beds	1,910,996	98,483	1,812,513	0	0 201.00
202.00		Total (line 200 minus line 201)	37,715,109	1,876,251	35,838,858	0	0 202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,789,860	19,460,812	0.246128	50.00
53.00	05300	ANESTHESIOLOGY	727,001	4,762,111	0.152664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,183,934	13,535,922	0.161344	54.00
56.00	05600	RADIOISOTOPE	277,008	3,964,828	0.069866	56.00
57.00	05700	CT SCAN	534,119	17,000,394	0.031418	57.00
58.00	05800	MRI	555,587	4,072,319	0.136430	58.00
60.00	06000	LABORATORY	4,028,429	29,036,259	0.138738	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	565,850	765,773	0.738927	64.00
65.00	06500	RESPIRATORY THERAPY	979,058	1,325,650	0.738549	65.00
66.00	06600	PHYSICAL THERAPY	3,926,813	16,246,805	0.241698	66.00
68.00	06800	SPEECH PATHOLOGY	687,184	1,424,396	0.482439	68.00
69.00	06900	ELECTROCARDIOLOGY	191,166	3,321,663	0.057551	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	203,981	8,716,121	0.023403	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,415	1,372,036	0.061525	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,301,297	10,707,104	0.214932	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,443,358	1,405,388	1.738565	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,109,174	1,469,665	1.435139	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,161,061	2,323,342	0.930152	88.02
91.00	09100	EMERGENCY	2,540,454	12,883,265	0.197190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,910,996	6,710,635	0.284771	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,473,572	2,762,354	1.257468	95.00
99.10	09910	CORF	0	0	0.000000	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0.000000	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000	99.40
101.00	10100	HOME HEALTH AGENCY	1,806,698	1,953,359	0.924919	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,145,090	2,368,971	0.483370	116.00
200.00		Subtotal (sum of lines 50 thru 199)	39,626,105	167,589,172		200.00
201.00		Less Observation Beds	1,910,996	0		201.00
202.00		Total (line 200 minus line 201)	37,715,109	167,589,172		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

			Title XVIII		Hospital	PPS		
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	383,275	0	383,275	4,962	77.24	30.00	
31.00	INTENSIVE CARE UNIT	96,034		96,034	571	168.19	31.00	
40.00	SUBPROVIDER - IPF	202	0	202	0	0.00	40.00	
43.00	NURSERY	26,034		26,034	463	56.23	43.00	
44.00	SKILLED NURSING FACILITY	165,803		165,803	6,825	24.29	44.00	
200.00	Total (lines 30 through 199)	671,348		671,348	12,821		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	2,283	176,339					30.00
31.00	INTENSIVE CARE UNIT	349	58,698					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	2,632	235,037					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Capital Related Cost (from Wkst. C, 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	307,060	19,460,812	0.015778	2,070,825	32,673	50.00
53.00	05300	ANESTHESIOLOGY	64,889	4,762,111	0.013626	377,851	5,149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	267,243	13,535,922	0.019743	1,458,270	28,791	54.00
56.00	05600	RADIOISOTOPE	33,856	3,964,828	0.008539	116,742	997	56.00
57.00	05700	CT SCAN	29,980	17,000,394	0.001763	1,569,200	2,766	57.00
58.00	05800	MRI	258,436	4,072,319	0.063462	167,275	10,616	58.00
60.00	06000	LABORATORY	161,876	29,036,259	0.005575	3,453,268	19,252	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	24,658	765,773	0.032200	231,438	7,452	64.00
65.00	06500	RESPIRATORY THERAPY	25,030	1,325,650	0.018881	771,503	14,567	65.00
66.00	06600	PHYSICAL THERAPY	85,338	16,246,805	0.005253	630,858	3,314	66.00
68.00	06800	SPEECH PATHOLOGY	11,569	1,424,396	0.008122	90,714	737	68.00
69.00	06900	ELECTROCARDIOLOGY	13,540	3,321,663	0.004076	349,730	1,425	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,378	8,716,121	0.000158	591,763	93	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	570	1,372,036	0.000415	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,544	10,707,104	0.001452	1,985,142	2,882	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	71,798	1,405,388	0.051088	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	44,221	1,469,665	0.030089	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	36,394	2,323,342	0.015665	0	0	88.02
91.00	09100	EMERGENCY	101,521	12,883,265	0.007880	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	98,483	6,710,635	0.014676	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	1,653,384	160,504,488		13,864,579	130,714	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part III
Date/Time Prepared:
8/26/2020 12:07 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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	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	4,962	0.00	2,283	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	571	0.00	349	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00	
43.00	04300	NURSERY		0	463	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	6,825	0.00	0	44.00	
200.00		Total (lines 30 through 199)		0	12,821		2,632	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
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 12:07 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	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: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 12:07 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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	19,460,812	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,762,111	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,535,922	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,964,828	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,000,394	0.000000	57.00
58.00	05800	MRI	0	0	0	4,072,319	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	29,036,259	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	765,773	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,325,650	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,246,805	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,424,396	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,321,663	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,716,121	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,372,036	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,707,104	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,405,388	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,469,665	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,323,342	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	12,883,265	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,710,635	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	160,504,488		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 12:07 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		2,070,825	0	5,142,764	0
53.00	05300	ANESTHESIOLOGY	0.000000		377,851	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		1,458,270	0	4,043,016	0
56.00	05600	RADIOISOTOPE	0.000000		116,742	0	1,849,669	0
57.00	05700	CT SCAN	0.000000		1,569,200	0	5,183,313	0
58.00	05800	MRI	0.000000		167,275	0	1,463,385	0
60.00	06000	LABORATORY	0.000000		3,453,268	0	3,735,594	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.000000		231,438	0	440,512	0
65.00	06500	RESPIRATORY THERAPY	0.000000		771,503	0	290,263	0
66.00	06600	PHYSICAL THERAPY	0.000000		630,858	0	49,399	0
68.00	06800	SPEECH PATHOLOGY	0.000000		90,714	0	40,643	0
69.00	06900	ELECTROCARDIOLOGY	0.000000		349,730	0	1,442,278	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		591,763	0	1,597,181	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		0	0	37,715	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		1,985,142	0	3,894,963	0
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0
76.99	07699	LITHOTRIPSY	0.000000		0	0	0	0
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	0	0	0
91.00	09100	EMERGENCY	0.000000		0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		0	0	0	0
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						
200.00		Total (lines 50 through 199)			13,864,579	0	29,210,695	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/26/2020 12:07 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	0.246128	5,142,764	0	0	1,265,778	50.00
53.00	05300	ANESTHESIOLOGY	0.152664	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161344	4,043,016	0	0	652,316	54.00
56.00	05600	RADIOISOTOPE	0.069866	1,849,669	0	0	129,229	56.00
57.00	05700	CT SCAN	0.031418	5,183,313	0	0	162,849	57.00
58.00	05800	MRI	0.136430	1,463,385	0	0	199,650	58.00
60.00	06000	LABORATORY	0.138738	3,735,594	0	0	518,269	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.738927	440,512	0	0	325,506	64.00
65.00	06500	RESPIRATORY THERAPY	0.738549	290,263	0	0	214,373	65.00
66.00	06600	PHYSICAL THERAPY	0.241698	49,399	0	0	11,940	66.00
68.00	06800	SPEECH PATHOLOGY	0.482439	40,643	0	0	19,608	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057551	1,442,278	0	0	83,005	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023403	1,597,181	0	0	37,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.061525	37,715	0	0	2,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214932	3,894,963	11,542	0	837,152	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.197190	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284771	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1.257468		0			95.00
200.00		Subtotal (see instructions)		29,210,695	11,542	0	4,459,374	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		29,210,695	11,542	0	4,459,374	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0147		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 8/26/2020 12:07 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,481	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,481	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,481	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 8/26/2020 12:07 pm	
				Component CCN: 14-S147			
				Title XVIII	Subprovider - IPF	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	307,060	19,460,812	0.015778	0	50.00
53.00	05300	ANESTHESIOLOGY	64,889	4,762,111	0.013626	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	267,243	13,535,922	0.019743	0	54.00
56.00	05600	RADIOISOTOPE	33,856	3,964,828	0.008539	0	56.00
57.00	05700	CT SCAN	29,980	17,000,394	0.001763	0	57.00
58.00	05800	MRI	258,436	4,072,319	0.063462	0	58.00
60.00	06000	LABORATORY	161,876	29,036,259	0.005575	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	62.30
64.00	06400	INTRAVENOUS THERAPY	24,658	765,773	0.032200	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,030	1,325,650	0.018881	0	65.00
66.00	06600	PHYSICAL THERAPY	85,338	16,246,805	0.005253	0	66.00
68.00	06800	SPEECH PATHOLOGY	11,569	1,424,396	0.008122	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,540	3,321,663	0.004076	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,378	8,716,121	0.000158	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	570	1,372,036	0.000415	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,544	10,707,104	0.001452	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	71,798	1,405,388	0.051088	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	44,221	1,469,665	0.030089	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	36,394	2,323,342	0.015665	0	88.02
91.00	09100	EMERGENCY	101,521	12,883,265	0.007880	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,710,635	0.000000	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	1,554,901	160,504,488		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				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	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
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: 14-0147 Component CCN: 14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
			Title XVIII		Subprovider - IPF		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	19,460,812	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,762,111	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,535,922	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,964,828	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,000,394	0.000000	57.00
58.00	05800	MRI	0	0	0	4,072,319	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	29,036,259	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	765,773	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,325,650	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,246,805	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,424,396	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,321,663	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,716,121	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,372,036	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,707,104	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,405,388	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,469,665	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,323,342	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	12,883,265	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,710,635	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	160,504,488		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES			0	0	0		95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0147

Period:

Worksheet D

Component CCN: 14-U147

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/26/2020 12:07 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	0.246128	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.152664	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161344	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.069866	0	0	0	0	56.00
57.00	05700	CT SCAN	0.031418	0	0	0	0	57.00
58.00	05800	MRI	0.136430	0	0	0	0	58.00
60.00	06000	LABORATORY	0.138738	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.738927	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.738549	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.241698	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.482439	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057551	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023403	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.061525	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214932	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.197190	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284771	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1.257468		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: 14-0147

Period:

Worksheet D

Component CCN: 14-U147

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/26/2020 12:07 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0147 Component CCN:14-5580		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				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	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
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: 14-0147 Component CCN: 14-5580		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
			Title XVIII		Skilled Nursing Facility		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	19,460,812	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,762,111	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,535,922	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,964,828	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,000,394	0.000000	57.00
58.00	05800	MRI	0	0	0	4,072,319	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	29,036,259	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	765,773	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,325,650	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,246,805	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,424,396	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,321,663	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,716,121	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,372,036	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,707,104	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,405,388	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,469,665	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	2,323,342	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	12,883,265	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,710,635	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	160,504,488		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0147 Component CCN:14-5580		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES			0	0	0		95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/26/2020 12:07 pm

			Title XIX		Hospital	PPS		
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	383,275	0	383,275	4,962	77.24	30.00	
31.00	INTENSIVE CARE UNIT	96,034		96,034	571	168.19	31.00	
40.00	SUBPROVIDER - IPF	202	0	202	0	0.00	40.00	
43.00	NURSERY	26,034		26,034	463	56.23	43.00	
44.00	SKILLED NURSING FACILITY	165,803		165,803	6,825	24.29	44.00	
200.00	Total (lines 30 through 199)	671,348		671,348	12,821		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	272	21,009					30.00
31.00	INTENSIVE CARE UNIT	42	7,064					31.00
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	34	1,912					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	348	29,985					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/26/2020 12:07 pm

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	PPS	
						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	307,060	0	0.000000	0	0	50.00
53.00	05300 ANESTHESIOLOGY	64,889	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	267,243	0	0.000000	0	0	54.00
56.00	05600 RADIOISOTOPE	33,856	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	29,980	0	0.000000	0	0	57.00
58.00	05800 MRI	258,436	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	161,876	0	0.000000	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	24,658	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	25,030	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	85,338	0	0.000000	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	11,569	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	13,540	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,378	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	570	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,544	0	0.000000	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	71,798	0	0.000000	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	44,221	0	0.000000	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	36,394	0	0.000000	0	0	88.02
91.00	09100 EMERGENCY	101,521	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	98,483	0	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES		0				95.00
200.00	Total (lines 50 through 199)	1,653,384	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part III
Date/Time Prepared:
8/26/2020 12:07 pm

				Title XIX		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	4,962	0.00	272	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	571	0.00	42	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	0	40.00	
43.00	04300	NURSERY		0	463	0.00	34	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	6,825	0.00	0	0	44.00	
200.00		Total (lines 30 through 199)		0	12,821		348	0	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
40.00	04000	SUBPROVIDER - IPF	0							40.00
43.00	04300	NURSERY	0							43.00
44.00	04400	SKILLED NURSING FACILITY	0							44.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 12:07 pm

			Title XIX		Hospital	PPS		
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	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: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 12:07 pm

			Title XIX		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description			Title XIX		Hospital		PPS
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0 54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0 56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800	MRI	0.000000	0	0	0	0 58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0 66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0 88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0 92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0 93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)		0	0	0	0 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0147 Component CCN:14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part II Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XIX		Subprovider - IPF		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		307,060	0	0.000000	0	0	50.00
53.00	05300	ANESTHESIOLOGY		64,889	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		267,243	0	0.000000	0	0	54.00
56.00	05600	RADIOISOTOPE		33,856	0	0.000000	0	0	56.00
57.00	05700	CT SCAN		29,980	0	0.000000	0	0	57.00
58.00	05800	MRI		258,436	0	0.000000	0	0	58.00
60.00	06000	LABORATORY		161,876	0	0.000000	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY		24,658	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		25,030	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY		85,338	0	0.000000	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		11,569	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		13,540	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		1,378	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		570	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		15,544	0	0.000000	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		71,798	0	0.000000	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		44,221	0	0.000000	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III		36,394	0	0.000000	0	0	88.02
91.00	09100	EMERGENCY		101,521	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		1,554,901	0		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0147 Component CCN:14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				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	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
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: 14-0147 Component CCN: 14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
			Title XIX		Subprovider - IPF		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0.000000	88.02
91.00	09100	EMERGENCY	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0147 Component CCN:14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	0	88.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES			0	0	0		95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/26/2020 12:07 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)	8,263	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,962	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)	3,687	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	3,301	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,283	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)	2,651	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,437,147	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,437,147	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)	7,437,147	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,498.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,421,806	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)	3,421,806	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/26/2020 12:07 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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,028,661	571	3,552.82	349	1,239,934	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,759,729	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,421,469	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					235,037	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					130,714	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					365,751	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,055,718	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,275	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,498.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,910,996	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0147		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 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	383,275	7,437,147	0.051535	1,910,996	98,483	90.00		
91.00	Nursing School cost	0	7,437,147	0.000000	1,910,996	0	91.00		
92.00	Allied health cost	0	7,437,147	0.000000	1,910,996	0	92.00		
93.00	All other Medical Education	0	7,437,147	0.000000	1,910,996	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 pm
		Title XVIII	Subprovider - IPF	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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		248	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		248	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)		248	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1	
				Component CCN: 14-S147		Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0147 Component CCN:14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XVIII		Subprovider - IPF		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			202	248	0.814516	0	0	90.00
91.00	Nursing School cost			0	248	0.000000	0	0	91.00
92.00	Allied health cost			0	248	0.000000	0	0	92.00
93.00	All other Medical Education			0	248	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-5580	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 pm
		Title XVIII	Skilled Nursing Facility	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)		6,825	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,825	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)		6,825	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,320,737	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,320,737	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,320,737	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1
				Component CCN: 14-5580		Date/Time Prepared: 8/26/2020 12:07 pm
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					3,320,737	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					486.55	71.00
72.00 Program routine service cost (line 9 x line 71)					0	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00 Program inpatient ancillary services (see instructions)					0	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0147 Component CCN: 14-5580		Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 pm	
			Title XVIII		Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 pm	
		Title XIX	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)			8,263	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,962	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)			3,687	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			3,301	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			272	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			463	15.00
16.00	Nursery days (title V or XIX only)			34	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			7,437,147	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			7,437,147	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)			7,437,147	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY					
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,498.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			407,679	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)			407,679	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description		Title XIX		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)	710,790	463	1,535.18	34	52,196	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,028,661	571	3,552.82	42	149,218	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					609,093	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					29,985	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					29,985	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					579,108	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,275	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,498.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,910,996	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0147		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XIX		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	383,275	7,437,147	0.051535	1,910,996	98,483	90.00		
91.00	Nursing School cost	0	7,437,147	0.000000	1,910,996	0	91.00		
92.00	Allied health cost	0	7,437,147	0.000000	1,910,996	0	92.00		
93.00	All other Medical Education	0	7,437,147	0.000000	1,910,996	0	93.00		

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 pm
		Title XIX	Subprovider - IPF	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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		463	15.00
16.00	Nursery days (title V or XIX only)		34	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		248	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		248	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)		248	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1	
				Component CCN: 14-S147		Date/Time Prepared: 8/26/2020 12:07 pm	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0147 Component CCN: 14-S147		Period: From 01/01/2019 To 12/31/2019		Worksheet D-1 Date/Time Prepared: 8/26/2020 12:07 pm	
		Title XIX		Subprovider - IPF		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	202	248	0.814516	0	0	90.00
91.00	Nursing School cost	0	248	0.000000	0	0	91.00
92.00	Allied health cost	0	248	0.000000	0	0	92.00
93.00	All other Medical Education	0	248	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/26/2020 12:07 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		3,242,534		30.00
31.00	03100	INTENSIVE CARE UNIT		2,679,971		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.246128	2,070,825	509,688	50.00
53.00	05300	ANESTHESIOLOGY	0.152664	377,851	57,684	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161344	1,458,270	235,283	54.00
56.00	05600	RADIOISOTOPE	0.069866	116,742	8,156	56.00
57.00	05700	CT SCAN	0.031418	1,569,200	49,301	57.00
58.00	05800	MRI	0.136430	167,275	22,821	58.00
60.00	06000	LABORATORY	0.138738	3,453,268	479,099	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.738927	231,438	171,016	64.00
65.00	06500	RESPIRATORY THERAPY	0.738549	771,503	569,793	65.00
66.00	06600	PHYSICAL THERAPY	0.241698	630,858	152,477	66.00
68.00	06800	SPEECH PATHOLOGY	0.482439	90,714	43,764	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057551	349,730	20,127	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023403	591,763	13,849	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.061525	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214932	1,985,142	426,671	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100	EMERGENCY	0.197190	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284771	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		13,864,579	2,759,729	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)		13,864,579		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3
			Component CCN: 14-U147		Date/Time Prepared: 8/26/2020 12:07 pm
			Title XVIII	Swing Beds - SNF	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,277,559	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.246128	0	50.00
53.00	05300	ANESTHESIOLOGY	0.152664	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161344	106,291	54.00
56.00	05600	RADIOISOTOPE	0.069866	5,634	56.00
57.00	05700	CT SCAN	0.031418	27,270	57.00
58.00	05800	MRI	0.136430	8,003	58.00
60.00	06000	LABORATORY	0.138738	274,425	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.738927	47,167	64.00
65.00	06500	RESPIRATORY THERAPY	0.738549	24,628	65.00
66.00	06600	PHYSICAL THERAPY	0.241698	2,566,979	66.00
68.00	06800	SPEECH PATHOLOGY	0.482439	142,446	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057551	16,157	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.023403	306,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.061525	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.214932	779,258	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
91.00	09100	EMERGENCY	0.197190	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.284771	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,305,089	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)		4,305,089	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/26/2020 12:07 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)			3,550,988	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			1,143,120	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)				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
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			10,400	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			3,864	2.04
3.00	Managed Care Simulated Payments			446,332	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			34.46	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)			4.95	30.00
31.00	Percentage of Medicaid patient days (see instructions)			22.83	31.00
32.00	Sum of lines 30 and 31			27.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.00	33.00
34.00	Disproportionate share adjustment (see instructions)			140,824	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/26/2020 12:07 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)		6,766,695,164	8,350,954,456	35.00
35.01	Factor 3 (see instructions)		0.000042460	0.000026433	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		287,314	220,731	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		214,895	55,484	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		270,379		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
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		5,119,575		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))		5,233,721		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			5,233,721	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			375,481	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)			5,609,202	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			5,609,202	61.00
62.00	Deductibles billed to program beneficiaries			751,276	62.00
63.00	Coinurance billed to program beneficiaries			3,410	63.00
64.00	Allowable bad debts (see instructions)			118,044	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			76,729	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			118,044	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4,931,245	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-27,590	70.93
70.94	HRR adjustment amount (see instructions)			-54,418	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Prepared: 8/26/2020 12:07 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)	2019	915,871	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)	2020	291,790	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		67,192	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,989,706	71.00
71.01	Sequestration adjustment (see instructions)		119,794	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		5,873,353	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-3,441	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
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)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/26/2020 12:07 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	3,550,988	0	3,550,988		3,550,988
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,143,120	0		1,143,120	1,143,120
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					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	10,400	0	10,400		10,400
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	3,864	0		3,864	3,864
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	446,332	0	331,180	115,152	446,332
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	0.1200	0.1200	0.1200	0.1200	
11.00	Disproportionate share adjustment (see instructions)	34.00	140,824	0	106,530	34,294	140,824
11.01	Uncompensated care payments	36.00	270,379	0	214,895	55,484	270,379
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	5,119,575	0	3,882,813	1,236,762	5,119,575
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	5,233,721	0	3,962,594	1,271,127	5,233,721
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,233,721	0	3,962,594	1,271,127	5,233,721

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
8/26/2020 12:07 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
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	375,481	0	291,337	84,144	375,481
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
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	4,253,931	1,355,271	5,609,202
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	374,741	0	291,842	82,899	374,741
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	-187	187	0
21.00	Capital DRG outlier payments	2.00	740	0	-318	1,058	740
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	375,481	0	291,337	84,144	375,481
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.215300	0.215300	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			915,871		915,871
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				291,790	291,790
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/26/2020 12:07 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,481	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,459,374	2.00
3.00	OPPS payments		4,376,528	3.00
4.00	Outlier payment (see instructions)		4,377	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.810	5.00
6.00	Line 2 times line 5		3,612,093	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)		2,481	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		11,542	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)		11,542	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)		11,542	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		9,061	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)		2,481	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)		4,380,905	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)		915,765	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)		3,467,621	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)		3,467,621	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,467,621	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)		98,588	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		64,082	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		98,588	36.00
37.00	Subtotal (see instructions)		3,531,703	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,531,703	40.00
40.01	Sequestration adjustment (see instructions)		70,634	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		3,490,524	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-29,455	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/26/2020 12:07 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		5,873,353		3,490,524	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		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)		5,873,353		3,490,524	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		3,441		29,455	6.02
7.00	Total Medicare program liability (see instructions)		5,869,912		3,461,069	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: 14-0147

Period:

Worksheet E-1

Component CCN: 14-U147

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 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		0		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)		0		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)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 8/26/2020 12:07 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: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2	
		Component CCN: 14-U147		Date/Time Prepared: 8/26/2020 12:07 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)		0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days	2,651		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)	0		0	8.00
9.00	Primary payer payments (see instructions)	0		0	9.00
10.00	Subtotal (line 8 minus line 9)	0		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)	0		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 (see instructions)	0		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)	0		0	19.00
19.01	Sequestration adjustment (see instructions)	0		0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0		0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments	0		0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)	0		0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0		0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147 Component CCN: 14-S147	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part II Date/Time Prepared: 8/26/2020 12:07 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		0	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		0.000000	9.00
10.00	Teaching Adjustment Factor {(1 + (line 8/line 9)) raised to the power of .5150 -1}.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		0	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		0	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		0	18.00
19.00	Deductibles		0	19.00
20.00	Subtotal (line 18 minus line 19)		0	20.00
21.00	Coinsurance		0	21.00
22.00	Subtotal (line 20 minus line 21)		0	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		0	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		0	31.00
31.01	Sequestration adjustment (see instructions)		0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		0	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147 Component CCN: 14-5580	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 8/26/2020 12:07 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet G

Date/Time Prepared:
8/26/2020 12:07 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	-969,363	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	35,394,108	0	0	0	4.00
5.00	Other receivable	1,226,121	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26,586,246	0	0	0	6.00
7.00	Inventory	873,309	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	446,922	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,384,851	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	57,747,337	0	0	0	15.00
16.00	Accumulated depreciation	-39,693,158	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	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)	18,054,179	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	1,063,892	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,063,892	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,502,922	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	794,410	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,039,994	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,342,352	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,176,756	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,489,024	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,489,024	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,665,780	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,837,142				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	7,837,142	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,502,922	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-1

Date/Time Prepared:
8/26/2020 12:07 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		18,165,994		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-10,328,852				2.00
3.00	Total (sum of line 1 and line 2)		7,837,142		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)		7,837,142		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)		7,837,142		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: 14-0147

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,249,669		10,249,669	1.00
2.00	SUBPROVIDER - IPF	0		0	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	1,222,033		1,222,033	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)	11,471,702		11,471,702	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,072,152		3,072,152	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)	3,072,152		3,072,152	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,543,854		14,543,854	17.00
18.00	Ancillary services	25,172,508	0	25,172,508	18.00
19.00	Outpatient services	0	130,133,585	130,133,585	19.00
20.00	RURAL HEALTH CLINIC	0	1,405,388	1,405,388	20.00
20.01	RURAL HEALTH CLINIC II	0	1,469,665	1,469,665	20.01
20.02	RURAL HEALTH CLINIC III	0	2,323,342	2,323,342	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,953,359	1,953,359	22.00
23.00	AMBULANCE SERVICES	0	2,762,354	2,762,354	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	44,566	2,324,405	2,368,971	26.00
27.00	PHYSICIAN PRIVATE OFFICES & PROFEES	3,295,742	23,370,950	26,666,692	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	43,056,670	165,743,048	208,799,718	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		66,214,945		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)		66,214,945		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0147

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-3

Date/Time Prepared:
8/26/2020 12:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	208,799,718	1.00
2.00	Less contractual allowances and discounts on patients' accounts	154,301,288	2.00
3.00	Net patient revenues (line 1 minus line 2)	54,498,430	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	66,214,945	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-11,716,515	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	99,993	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	127,000	13.00
14.00	Revenue from meals sold to employees and guests	265,981	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	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	OTHER (PROFESSIONAL	894,689	24.00
25.00	Total other income (sum of lines 6-24)	1,387,663	25.00
26.00	Total (line 5 plus line 25)	-10,328,852	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-10,328,852	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0147

Period:

Worksheet H

HHA CCN: 14-7187

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

8/26/2020 12:07 pm

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	147,359	0	2,024	0	146,245	295,628	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	512,439	0	27,466	0	0	539,905	6.00
7.00 Physical Therapy	0	0	18,853	0	0	18,853	7.00
8.00 Occupational Therapy	0	0	10,485	0	0	10,485	8.00
9.00 Speech Pathology	0	0	3,023	0	0	3,023	9.00
10.00 Medical Social Services	0	0	27	0	0	27	10.00
11.00 Home Health Aide	171,016	0	9,989	0	0	181,005	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	830,814	0	71,867	0	146,245	1,048,926	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	0	295,628	0	295,628			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	539,905	0	539,905			6.00
7.00 Physical Therapy	0	18,853	0	18,853			7.00
8.00 Occupational Therapy	0	10,485	0	10,485			8.00
9.00 Speech Pathology	0	3,023	0	3,023			9.00
10.00 Medical Social Services	0	27	0	27			10.00
11.00 Home Health Aide	0	181,005	0	181,005			11.00
12.00 Supplies (see instructions)	0	0	0	0			12.00
13.00 Drugs	0	0	0	0			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	0	1,048,926	0	1,048,926			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0147

Period:

Worksheet H-1

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportatio n	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	295,628	0	0	0	0	295,628	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	539,905	0	0	0	0	539,905	6.00
7.00	Physical Therapy	18,853	0	0	0	0	18,853	7.00
8.00	Occupational Therapy	10,485	0	0	0	0	10,485	8.00
9.00	Speech Pathology	3,023	0	0	0	0	3,023	9.00
10.00	Medical Social Services	27	0	0	0	0	27	10.00
11.00	Home Health Aide	181,005	0	0	0	0	181,005	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,048,926	0	0	0	0	1,048,926	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	295,628						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	211,882	751,787					6.00
7.00	Physical Therapy	7,399	26,252					7.00
8.00	Occupational Therapy	4,115	14,600					8.00
9.00	Speech Pathology	1,186	4,209					9.00
10.00	Medical Social Services	11	38					10.00
11.00	Home Health Aide	71,035	252,040					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,048,926					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet H-1

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/26/2020 12:07 pmHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportatio n (MILEAGE)	Reconciliatio n	Administrativ e & General (ACCUM. COST)	
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-295,628	753,298	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	539,905	6.00
7.00	Physical Therapy	0	0	0	0	0	18,853	7.00
8.00	Occupational Therapy	0	0	0	0	0	10,485	8.00
9.00	Speech Pathology	0	0	0	0	0	3,023	9.00
10.00	Medical Social Services	0	0	0	0	0	27	10.00
11.00	Home Health Aide	0	0	0	0	0	181,005	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-295,628	753,298	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		295,628	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.392445	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	6,269	74	329,547	335,890	81,293	1.00
2.00	Skilled Nursing Care	751,787	0	0	0	751,787	181,949	2.00
3.00	Physical Therapy	26,252	0	0	0	26,252	6,354	3.00
4.00	Occupational Therapy	14,600	0	0	0	14,600	3,534	4.00
5.00	Speech Pathology	4,209	0	0	0	4,209	1,019	5.00
6.00	Medical Social Services	38	0	0	0	38	9	6.00
7.00	Home Health Aide	252,040	0	0	0	252,040	60,999	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,048,926	6,269	74	329,547	1,384,816	335,157	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	17,910	8,757	0	26,672	0	16,396	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	17,910	8,757	0	26,672	0	16,396	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pmHome Health
Agency I

PPS

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	16,990	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	16,990	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
		19.00	20.00	SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV	23.00	24.00	
1.00	Administrative and General	0	0	0	0	0	503,908	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	933,736	2.00
3.00	Physical Therapy	0	0	0	0	0	32,606	3.00
4.00	Occupational Therapy	0	0	0	0	0	18,134	4.00
5.00	Speech Pathology	0	0	0	0	0	5,228	5.00
6.00	Medical Social Services	0	0	0	0	0	47	6.00
7.00	Home Health Aide	0	0	0	0	0	313,039	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,806,698	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pmHome Health
Agency I

PPS

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General	0	503,908				1.00
2.00	Skilled Nursing Care	0	933,736	361,161	1,294,897		2.00
3.00	Physical Therapy	0	32,606	12,612	45,218		3.00
4.00	Occupational Therapy	0	18,134	7,014	25,148		4.00
5.00	Speech Pathology	0	5,228	2,022	7,250		5.00
6.00	Medical Social Services	0	47	18	65		6.00
7.00	Home Health Aide	0	313,039	121,081	434,120		7.00
8.00	Supplies (see instructions)	0	0	0	0		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	0	1,806,698	503,908	1,806,698		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.386791			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/26/2020 12:07 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE -NEW)					
		1.00	2.00				4.00	
1.00	Administrative and General	1,333	70	830,815	0	335,890	1,333	1.00
2.00	Skilled Nursing Care	0	0	0	0	751,787	0	2.00
3.00	Physical Therapy	0	0	0	0	26,252	0	3.00
4.00	Occupational Therapy	0	0	0	0	14,600	0	4.00
5.00	Speech Pathology	0	0	0	0	4,209	0	5.00
6.00	Medical Social Services	0	0	0	0	38	0	6.00
7.00	Home Health Aide	0	0	0	0	252,040	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,333	70	830,815		1,384,816	1,333	20.00
21.00	Total cost to be allocated	6,269	74	329,547		335,157	17,910	21.00
22.00	Unit cost multiplier	4.702926	1.057143	0.396655		0.242023	13.435859	22.00
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (DIETARY MEALS SERV)	CAFETERIA (CAFE MEALS SERV)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	1,333	0	156	0	15	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,333	0	156	0	15	0	20.00
21.00	Total cost to be allocated	8,757	0	26,672	0	16,396	0	21.00
22.00	Unit cost multiplier	6.569392	0.000000	170.974359	0.000000	1,093.066667	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet H-2

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/26/2020 12:07 pmHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATIO N (DIRECT NUR SING HO)		CENTRAL SERVICES & SUPPLY (CS COSTED REQUIS)		PHARMACY (PHARM COST ED REQ)		MEDICAL RECORDS & LIBRARY (TIME SPENT)		SOCIAL SERVICE (TIME SPENT)		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)			
		13.00		14.00		15.00		16.00		17.00		19.00			
1.00	Administrative and General		0		71,866		0		0		0		0		1.00
2.00	Skilled Nursing Care		0		0		0		0		0		0		2.00
3.00	Physical Therapy		0		0		0		0		0		0		3.00
4.00	Occupational Therapy		0		0		0		0		0		0		4.00
5.00	Speech Pathology		0		0		0		0		0		0		5.00
6.00	Medical Social Services		0		0		0		0		0		0		6.00
7.00	Home Health Aide		0		0		0		0		0		0		7.00
8.00	Supplies (see instructions)		0		0		0		0		0		0		8.00
9.00	Drugs		0		0		0		0		0		0		9.00
10.00	DME		0		0		0		0		0		0		10.00
11.00	Home Dialysis Aide Services		0		0		0		0		0		0		11.00
12.00	Respiratory Therapy		0		0		0		0		0		0		12.00
13.00	Private Duty Nursing		0		0		0		0		0		0		13.00
14.00	Clinic		0		0		0		0		0		0		14.00
15.00	Health Promotion Activities		0		0		0		0		0		0		15.00
16.00	Day Care Program		0		0		0		0		0		0		16.00
17.00	Home Delivered Meals Program		0		0		0		0		0		0		17.00
18.00	Homemaker Service		0		0		0		0		0		0		18.00
19.00	All Others (specify)		0		0		0		0		0		0		19.00
19.50	Telemedicine		0		0		0		0		0		0		19.50
20.00	Total (sum of lines 1-19)		0		71,866		0		0		0		0		20.00
21.00	Total cost to be allocated		0		16,990		0		0		0		0		21.00
22.00	Unit cost multiplier		0.000000		0.236412		0.000000		0.000000		0.000000		0.000000		22.00
Cost Center Description		NURSING SCHOOL (ASSIGNED TIME)		INTERNS & RESIDENTS				PARAMED PRGM (ASSIGNED TIME)							
				SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)		SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)									
				20.00		21.00		22.00		23.00					
1.00	Administrative and General		0		0		0		0						1.00
2.00	Skilled Nursing Care		0		0		0		0						2.00
3.00	Physical Therapy		0		0		0		0						3.00
4.00	Occupational Therapy		0		0		0		0						4.00
5.00	Speech Pathology		0		0		0		0						5.00
6.00	Medical Social Services		0		0		0		0						6.00
7.00	Home Health Aide		0		0		0		0						7.00
8.00	Supplies (see instructions)		0		0		0		0						8.00
9.00	Drugs		0		0		0		0						9.00
10.00	DME		0		0		0		0						10.00
11.00	Home Dialysis Aide Services		0		0		0		0						11.00
12.00	Respiratory Therapy		0		0		0		0						12.00
13.00	Private Duty Nursing		0		0		0		0						13.00
14.00	Clinic		0		0		0		0						14.00
15.00	Health Promotion Activities		0		0		0		0						15.00
16.00	Day Care Program		0		0		0		0						16.00
17.00	Home Delivered Meals Program		0		0		0		0						17.00
18.00	Homemaker Service		0		0		0		0						18.00
19.00	All Others (specify)		0		0		0		0						19.00
19.50	Telemedicine		0		0		0		0						19.50
20.00	Total (sum of lines 1-19)		0		0		0		0						20.00
21.00	Total cost to be allocated		0		0		0		0						21.00
22.00	Unit cost multiplier		0.000000		0.000000		0.000000		0.000000						22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet H-3

HHA CCN: 14-7187

From 01/01/2019

Part I

To 12/31/2019

Date/Time Prepared:

8/26/2020 12:07 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,294,897		1,294,897	6,648	194.78	1.00
2.00	Physical Therapy	3.00	45,218	0	45,218	3,521	12.84	2.00
3.00	Occupational Therapy	4.00	25,148	0	25,148	803	31.32	3.00
4.00	Speech Pathology	5.00	7,250	0	7,250	307	23.62	4.00
5.00	Medical Social Services	6.00	65		65	81	0.80	5.00
6.00	Home Health Aide	7.00	434,120		434,120	1,012	428.97	6.00
7.00	Total (sum of lines 1-6)		1,806,698	0	1,806,698	12,372		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	4,172			8.00
9.00	Physical Therapy		99914	0	2,548			9.00
10.00	Occupational Therapy		99914	0	585			10.00
11.00	Speech Pathology		99914	0	190			11.00
12.00	Medical Social Services		99914	0	40			12.00
13.00	Home Health Aide		99914	0	953			13.00
14.00	Total (sum of lines 8-13)			0	8,488			14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Cost Center Description		Program Visits			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	4,172		0	812,622		1.00
2.00	Physical Therapy	0	2,548		0	32,716		2.00
3.00	Occupational Therapy	0	585		0	18,322		3.00
4.00	Speech Pathology	0	190		0	4,488		4.00
5.00	Medical Social Services	0	40		0	32		5.00
6.00	Home Health Aide	0	953		0	408,808		6.00
7.00	Total (sum of lines 1-6)	0	8,488		0	1,276,988		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet H-3

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	812,622							1.00
2.00	Physical Therapy	32,716							2.00
3.00	Occupational Therapy	18,322							3.00
4.00	Speech Pathology	4,488							4.00
5.00	Medical Social Services	32							5.00
6.00	Home Health Aide	408,808							6.00
7.00	Total (sum of lines 1-6)	1,276,988							7.00
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
9.00	Physical Therapy								9.00
10.00	Occupational Therapy								10.00
11.00	Speech Pathology								11.00
12.00	Medical Social Services								12.00
13.00	Home Health Aide								13.00
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet H-3

HHA CCN: 14-7187

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.241698	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology	68.00	0.482439	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.023403	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.214932	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0147 HHA CCN: 14-7187	Period: From 01/01/2019 To 12/31/2019	Worksheet H-4 Part I-II Date/Time Prepared: 8/26/2020 12:07 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,102,831	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	117,510	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	23,147	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	12,573	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	2,010	16.00
17.00	Total Other Payments	0	49,038	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,307,109	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,307,109	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,307,109	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,307,109	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	1,307,109	31.00
31.01	Sequestration adjustment (see instructions)	0	26,143	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	1,280,966	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 HHA CCN: 14-7187		Period: From 01/01/2019 To 12/31/2019		Worksheet H-5 Date/Time Prepared: 8/26/2020 12:07 pm	
				Home Health Agency I		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		0		1,280,966	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			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			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. H-4, Part II, column as appropriate, line 32)		0		1,280,966	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		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50			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)		0		1,280,966	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0

Hospice CCN: 14-1542

From 01/01/2019

To 12/31/2019

Date/Time Prepared:

8/26/2020 12:07 pm

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	51,623	272,944	324,567	0	324,567	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	743	743	0	743	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	97,726	97,726	0	97,726	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	32,657	32,657	0	32,657	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	2	0	2	0	2	28.00
29.00	LPN/LVN**	120,631	0	120,631	0	120,631	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING**	32,772	0	32,772	0	32,772	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	107,086	0	107,086	0	107,086	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	312,114	404,070	716,184	0	716,184	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	324,567	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	743	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	97,726	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	32,657	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	13.00
14.00	PHARMACY*	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	2	28.00
29.00	LPN/LVN**	0	120,631	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	0	33.00
34.00	SPIRITUAL COUNSELING**	0	32,772	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	107,086	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	716,184	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0147

Period:

Worksheet 0-2

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

				Hospice I		07/20/2020 12:07 pm	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	120,631	0	120,631	0	120,631	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	32,772	0	32,772	0	32,772	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	107,086	0	107,086	0	107,086	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	260,489	0	260,489	0	260,489	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	120,631	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	32,772	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	107,086	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	260,489	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 14-0147

Period:

Worksheet 0-3

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1	0	1	0	1	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1	0	1	0	1	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 14-0147

Period:

Worksheet 0-4

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

				Hospice I		07/20/2020 12:07 pm	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	1	0	1	0	1	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1	0	1	0	1	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	1	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 14-0147

Period:

Worksheet 0-5

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	6,269	6,269	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	833	833	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	123,801	123,801	3.00
4.00	ADMINISTRATIVE & GENERAL	324,567	218,132	542,699	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	26,667	26,667	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	26,672	26,672	7.00
8.00	DIETARY	743	0	743	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	97,726	26,532	124,258	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	32,657	0	32,657	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	13.00
14.00	PHARMACY	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	260,489	0	260,489	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1	0	1	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1	0	1	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	716,184	428,906	1,145,090	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	6,269	6,269					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	833		833				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	123,801	0	0	123,801			3.00
4.00	ADMINISTRATIVE & GENERAL	542,699	6,269	833	123,801	673,602		4.00
5.00	PLANT OPERATION & MAINTENANCE	26,667	0	0	0	26,667		5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0		6.00
7.00	HOUSEKEEPING	26,672	0	0	0	26,672		7.00
8.00	DIETARY	743	0	0	0	743		8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	124,258	0	0	0	124,258		10.00
11.00	MEDICAL RECORDS	0	0	0	0	0		11.00
12.00	STAFF TRANSPORTATION	32,657	0	0	0	32,657		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0		13.00
14.00	PHARMACY	0	0	0	0	0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0		15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0		50.00
51.00	HOSPICE ROUTINE HOME CARE	260,489			0	260,489		51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1	0	0	0	1		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1	0	0	0	1		53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0		60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0		61.00
62.00	FUNDRAISING	0	0	0	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0		66.00
67.00	ADVERTISING	0	0	0	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0		68.00
69.00	THRIFT STORE	0	0	0	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0		71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0		99.00
100.00	TOTAL	1,145,090	6,269	833	123,801	1,145,090		100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	673,602						4.00
5.00	PLANT OPERATION & MAINTENANCE	38,098	64,765					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	38,106	0			64,778		7.00
8.00	DIETARY	1,062	0			0	1,805	8.00
9.00	NURSING ADMINISTRATION	0	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	177,524	0			0		10.00
11.00	MEDICAL RECORDS	0	0			0		11.00
12.00	STAFF TRANSPORTATION	46,656	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0			0		13.00
14.00	PHARMACY	0	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	0	64,765			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	372,154						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1	0		0	64,778	341	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1	0		0	0	528	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	936	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	673,602	64,765		0	64,778	1,805	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Descriptions		Hospice I					
		NURSING ADMINISTRATIO N	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATIO N	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	301,782				10.00
11.00	MEDICAL RECORDS	0		0			11.00
12.00	STAFF TRANSPORTATION	0			79,313		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	299,179	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1,021	0	79,313	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	1,582	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	301,782	0	79,313	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 12:07 pm

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	0					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		64,765			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0		931,822	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	64,765	0	210,220	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	2,112	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	936	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	0	64,765	0	1,145,090	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATIO N	ADMINISTRATIV E & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,333					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		793				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1			3.00
4.00	ADMINISTRATIVE & GENERAL	1,333	793	1	-673,602	471,488	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	26,667	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	26,672	7.00
8.00	DIETARY	0	0	0	0	743	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	124,258	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	32,657	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			0	0	260,489	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	1	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	1	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	6,269	833	123,801		673,602	100.00
101.00	UNIT COST MULTIPLIER	4.702926	1.050441	123,801.00000	0	1.428673	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATIO N (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	1,333					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		1			7.00
8.00	DIETARY	0		0	106		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	1,333		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	1	20	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	31	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	55	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	64,765	0	64,778	1,805	0	100.00
101.00	UNIT COST MULTIPLIER	48.585896	0.000000	64,778.000000	17.028302	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,914					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			1			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	5,863	0	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	20	0	1	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	31	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	301,782	0	79,313	0	0	100.00
101.00	UNIT COST MULTIPLIER	51.028407	0.000000	79,313.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0147

Period:

Worksheet 0-6

Hospice CCN: 14-1542

From 01/01/2019

Part II

To 12/31/2019

Date/Time Prepared:
8/26/2020 12:07 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		1			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	64,765	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	64,765.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 14-0147

Period:

Worksheet 0-7

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019

Date/Time Prepared:
8/26/2020 12:07 pm

Hospice I

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				2.00	3.00	4.00	
		0	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.241698	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00	0.482439	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.214932	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.138738	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.023403	0	0	0	7.00
8.99	PARTIAL HOSPITALIZATION PROGRAM	93.99	0.000000	0	0	0	8.99
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.97	CARDIAC REHABILITATION	76.97	0.000000	0	0	0	10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98	0.000000	0	0	0	10.98
10.99	LITHOTRIPSY	76.99	0.000000	0	0	0	10.99
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.99	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	8.99
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
10.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	10.98
10.99	LITHOTRIPSY	0	0	0	0	0	10.99
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0147

Period:

Worksheet 0-8

Hospice CCN: 14-1542

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			931,822	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			5,863	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			158.93	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	5,331	260		9.00
10.00	Program cost (line 8 times line 9)	847,256	41,322		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			210,220	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			20	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			10,511.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			2,112	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			31	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			68.13	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	31	0		19.00
20.00	Program cost (line 18 times line 19)	2,112	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,144,154	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			5,914	22.00
23.00	Average cost per diem (line 21 divided by line 22)			193.47	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0147	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Prepared: 8/26/2020 12:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		374,741	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		740	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)		11.67	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)		375,481	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: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8548

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 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	302,648	0	302,648	0	302,648
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	190,944	0	190,944	0	190,944
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	229,837	0	229,837	0	229,837
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	43,299	0	43,299	0	43,299
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	766,728	0	766,728	0	766,728
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	33,771	33,771	0	33,771
16.00	Transportation (Health Care Staff)	0	19,086	19,086	0	19,086
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	52,857	52,857	0	52,857
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	766,728	52,857	819,585	0	819,585
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	30,693	30,693	0	30,693
30.00	Administrative Costs	146,306	70,067	216,373	0	216,373
31.00	Total Facility Overhead (sum of lines 29 and 30)	146,306	100,760	247,066	0	247,066
32.00	Total facility costs (sum of lines 22, 28 and 31)	913,034	153,617	1,066,651	0	1,066,651

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8548

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 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	0	302,648	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	190,944	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	229,837	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	43,299	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	766,728	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	33,771	15.00
16.00	Transportation (Health Care Staff)	0	19,086	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	52,857	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	819,585	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	30,693	29.00
30.00	Administrative Costs	0	216,373	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	247,066	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,066,651	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8586

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		RHC II		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	197,893	0	197,893	0	197,893
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	124,853	0	124,853	0	124,853
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	150,285	0	150,285	0	150,285
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	28,312	0	28,312	0	28,312
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	501,343	0	501,343	0	501,343
11.00	Physician Services Under Agreement	0	483,750	483,750	0	483,750
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	483,750	483,750	0	483,750
15.00	Medical Supplies	0	45,812	45,812	0	45,812
16.00	Transportation (Health Care Staff)	0	1,957	1,957	0	1,957
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	47,769	47,769	0	47,769
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	501,343	531,519	1,032,862	0	1,032,862
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	1,421	1,421	0	1,421
30.00	Administrative Costs	95,666	59,315	154,981	0	154,981
31.00	Total Facility Overhead (sum of lines 29 and 30)	95,666	60,736	156,402	0	156,402
32.00	Total facility costs (sum of lines 22, 28 and 31)	597,009	592,255	1,189,264	0	1,189,264

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8586

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	197,893	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	124,853	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	150,285	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	28,312	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	501,343	10.00
11.00	Physician Services Under Agreement	0	483,750	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	483,750	14.00
15.00	Medical Supplies	0	45,812	15.00
16.00	Transportation (Health Care Staff)	0	1,957	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	47,769	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,032,862	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	1,421	29.00
30.00	Administrative Costs	0	154,981	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	156,402	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,189,264	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8584

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		RHC III		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	237,398	0	237,398	0	237,398
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	149,777	0	149,777	0	149,777
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	180,285	0	180,285	0	180,285
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	33,964	0	33,964	0	33,964
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	601,424	0	601,424	0	601,424
11.00	Physician Services Under Agreement	0	437,262	437,262	0	437,262
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	437,262	437,262	0	437,262
15.00	Medical Supplies	0	39,108	39,108	0	39,108
16.00	Transportation (Health Care Staff)	0	8,482	8,482	0	8,482
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	47,590	47,590	0	47,590
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	601,424	484,852	1,086,276	0	1,086,276
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	6,790	6,790	0	6,790
30.00	Administrative Costs	114,763	85,332	200,095	0	200,095
31.00	Total Facility Overhead (sum of lines 29 and 30)	114,763	92,122	206,885	0	206,885
32.00	Total facility costs (sum of lines 22, 28 and 31)	716,187	576,974	1,293,161	0	1,293,161

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0147

Period:

Worksheet M-1

Component CCN: 14-8584

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		RHC III		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	237,398	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	149,777	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	180,285	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	33,964	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	601,424	10.00
11.00	Physician Services Under Agreement	0	437,262	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	437,262	14.00
15.00	Medical Supplies	0	39,108	15.00
16.00	Transportation (Health Care Staff)	0	8,482	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	47,590	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,086,276	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	6,790	29.00
30.00	Administrative Costs	0	200,095	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	206,885	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,293,161	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8548

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 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	0.90	3,303	4,200	3,780	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.90	3,510	2,100	3,990	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.80	6,813		7,770	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)	2.80	6,813		7,770	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)				819,585	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)				819,585	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)				247,066	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,376,707	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,623,773	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,623,773	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,623,773	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,443,358	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8586

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		RHC II		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.64	2,516	4,200	2,688	1.00
2.00	Physician Assistant	1.00	577	2,100	2,100	2.00
3.00	Nurse Practitioner	1.29	2,680	2,100	2,709	3.00
4.00	Subtotal (sum of lines 1 through 3)	2.93	5,773		7,497	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)	2.93	5,773		7,497	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,032,862	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)				1,032,862	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)				156,402	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				919,910	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,076,312	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,076,312	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,076,312	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,109,174	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0147

Period:

Worksheet M-2

Component CCN: 14-8584

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 12:07 pm

		RHC III		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.00	2,883	4,200	4,200	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	3.42	10,830	2,100	7,182	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.42	13,713		11,382	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.42	13,713		13,713	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				1,086,276	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)				1,086,276	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)				206,885	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				867,900	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,074,785	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,074,785	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,074,785	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				2,161,061	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147 Component CCN: 14-8548	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/26/2020 12:07 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)			2,443,358	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			104,189	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,339,169	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,770	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)			7,770	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			301.05	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	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			301.05	301.05	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,249	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	978,111	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	978,111	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			473,349	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			754,701	16.04	
16.05	Total program cost (see instructions)		0	754,701	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			34,735	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			87,719	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			754,701	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			130,238	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			884,939	22.00	
23.00	Allowable bad debts (see instructions)			18,409	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			11,966	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,715	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)			896,905	26.00	
26.01	Sequestration adjustment (see instructions)			17,938	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			597,769	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)			281,198	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147 Component CCN: 14-8586	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/26/2020 12:07 pm		
		Title XVIII	RHC II	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)			2,109,174	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			36,479	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,072,695	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			7,497	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)			7,497	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			276.47	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	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			276.47	276.47	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,619	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	447,605	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	447,605	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			264,953	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			335,922	16.04	
16.05	Total program cost (see instructions)		0	335,922	16.05	
17.00	Primary payer amounts			186	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			27,702	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			47,448	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			335,736	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			20,176	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			355,912	22.00	
23.00	Allowable bad debts (see instructions)			10,154	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			6,600	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,503	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)			362,512	26.00	
26.01	Sequestration adjustment (see instructions)			7,250	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			180,055	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)			175,207	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0147 Component CCN: 14-8584	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/26/2020 12:07 pm		
		Title XVIII	RHC III	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)			2,161,061	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			52,124	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,108,937	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,713	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)			13,713	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			153.79	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	83.45	8.00
9.00	Rate for Program covered visits (see instructions)			153.79	153.79	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,909	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	293,585	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	293,585	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			322,928	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			214,926	16.04	
16.05	Total program cost (see instructions)		0	214,926	16.05	
17.00	Primary payer amounts			155	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			24,928	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			59,598	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			214,771	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			48,454	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			263,225	22.00	
23.00	Allowable bad debts (see instructions)			7,761	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			5,045	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,915	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)			268,270	26.00	
26.01	Sequestration adjustment (see instructions)			5,365	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			208,924	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)			53,981	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: 14-0147 Component CCN: 14-8548	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 8/26/2020 12:07 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)		766,728	766,728	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.002765	0.018633	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,120	14,286	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		18,525	17	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		20,645	14,303	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		819,585	819,585	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,623,773	1,623,773	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.025190	0.017452	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		40,903	28,338	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		61,548	42,641	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		119	208	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		517.21	205.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		144	272	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		74,478	55,760	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)			104,189	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)			130,238	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0147 Component CCN: 14-8586	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 8/26/2020 12:07 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		501,343	501,343	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000194	0.008568	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		97	4,296	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		10,395	3,076	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		10,492	7,372	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,032,862	1,032,862	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,076,312	1,076,312	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010158	0.007137	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		10,933	7,682	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		21,425	15,054	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		94	117	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		227.93	128.67	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		49	70	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		11,169	9,007	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)			36,479	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)			20,176	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0147 Component CCN: 14-8584	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 8/26/2020 12:07 pm	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		601,424	601,424	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000333	0.034631	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		200	20,828	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,646	1,526	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,846	22,354	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,086,276	1,086,276	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,074,785	1,074,785	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003541	0.020579	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		3,806	22,118	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		7,652	44,472	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		31	37	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		246.84	1,201.95	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		21	36	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		5,184	43,270	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)			52,124	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)			48,454	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8548	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/26/2020 12:07 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		597,769	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		597,769	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		281,198	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		878,967	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8586	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/26/2020 12:07 pm
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		87,955	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		08/06/2019	92,100	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		92,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		180,055	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		175,207	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		355,262	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0147 Component CCN: 14-8584	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/26/2020 12:07 pm	
			RHC III	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			155,872	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		08/06/2019		53,052	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			53,052	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			208,924	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			53,981	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			262,905	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00