

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/25/2019 11:03 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/25/2019	Time: 11:03 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SARAH BUSH LINCOLN HEALTH CENTER (14-0189) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

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	-157,167	-102,833	0	0	1.00
2.00	Subprovider - IPF	0	70,480	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
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		69		0	10.00
10.01	RURAL HEALTH CLINIC II	0		2,620		0	10.01
10.02	RURAL HEALTH CLINIC III	0		4,501		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		2,509		0	10.03
10.04	RURAL HEALTH CLINIC V	0		6,650		0	10.04
200.00	Total	0	-86,687	-86,484	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.

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Provider use only	1. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/25/2019 Time: 11:03 am
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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☐ 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.

Encryption Information

ECR: Date: 11/25/2019 Time: 11:03 am
UX9x:l878wxmMx0VoQF.0Smzhq2M00
kdBxr0JgK7k7xAnTS0NQVMWYP93vmC
GddY1A9LHp0FrBzf
PI: Date: 11/25/2019 Time: 11:03 am
VMYB6YaFFRsmUYcqAFRwCUI1aQtK00
S7Zh.01B1JLqsbH.LzweL5ZnnFo3UD
eZYG0XvC730eUZ4:

(Signed)

Officer or Administrator of Provider(s)

Title

Date

		Title XVIII		HIT	Title XIX	
Title V		Part A	Part B			
1.00		2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-157,167	-102,833	0	1.00
2.00	Subprovider - IPF	0	70,480	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
8.00	NURSING FACILITY	0			0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0		69	0	10.00
10.01	RURAL HEALTH CLINIC II	0		2,620	0	10.01
10.02	RURAL HEALTH CLINIC III	0		4,501	0	10.02
10.03	RURAL HEALTH CLINIC IV	0		2,509	0	10.03
10.04	RURAL HEALTH CLINIC V	0		6,650	0	10.04
200.00	Total	0	-86,687	-86,484	0	200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0189		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 9:04 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1000 HEALTH CENTER DRIVE		PO Box: 372						1.00	
2.00	City: MATTOON		State: IL		Zip Code: 61920-		County: COLES		2.00	
			Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
								8.00		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		SARAH BUSH LINCOLN HEALTH CENTER	140189	99914	1	05/01/1977	N	P	O
4.00	Subprovider - IPF		SARAH BUSH LINCOLN HEALTH CENTER	14S189	99914	4	01/01/1990	N	P	O
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		LINCOLN LAND HOME CARE OF SBLHS	147594	99914		06/18/1996	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice		LINCOLN LAND HOSPICE OF SBLHS	141599	99914		08/10/1999			
15.00	Hospital-Based Health Clinic - RHC		CASEY RHC	143978	99914		06/15/1992	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		SULLIVAN RHC	143998	99914		01/13/1995	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		NEOGA RHC	143435	99914		05/31/1997	N	O	N
15.03	Hospital-Based Health Clinic - RHC IV		NEWTON RHC	148541	99914		07/01/2014	N	O	N
15.04	Hospital-Based Health Clinic - RHC V		MARTINSVILLE RHC	148555	99914		07/01/2015	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019		
21.00	Type of Control (see instructions)						2			
							1.00	2.00		
							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			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			

Worksheet S-2
Part I
Date/Time Prepared:
11/25/2019 9:04 am

MCRIF32 - 15.9.167.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0189		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 9:04 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under \$413.85? (see instructions)		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/25/2019 9:04 am

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

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				1.00				
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			Y	N	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.06		
Rural Providers								
105.00	Does this hospital qualify as a CAH?			N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N	109.00
						1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 9:04 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	5,291,331	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0189		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/25/2019 9:04 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		N	
156.00	Subprovider - IPF	N		N		N		N	
157.00	Subprovider - IRF	N		N		N		N	
158.00	SUBPROVIDER								
159.00	SNF	N		N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/03/2018	12/31/2018		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 9:04 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/10/2019	Y 10/10/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/25/2019 9:04 am
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BARB	IPPOLITO	41.00
42.00	Enter the employer/company name of the cost report preparer.	SARAH BUSH LINCOLN HEALTH CENTER		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-258-2509	BIPPOLITO@SBLHS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/25/2019 9:04 am

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

HFS Supplemental Information

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part IX
Date/Time Prepared:
11/25/2019 9:04 am

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 9:04 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	73	26,645	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)		73	26,645	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT	32.00	9	3,285	0.00	0	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)		82	29,930	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	45.00	0	0		0	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	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
26.04 RURAL HEALTH CLINIC V	88.04				0	26.04
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		102				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: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 9:04 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,838	677	16,137			1.00
2.00	HMO and other (see instructions)	1,938	3,046				2.00
3.00	HMO IPF Subprovider	51	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			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)	8,838	677	16,137			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT	947	70	1,704			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		51	1,240			13.00
14.00	Total (see instructions)	9,785	798	19,081	0.00	1,860.87	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,566	2,082	4,939	0.00	31.74	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	19,738	0	29,337	0.00	56.81	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	29.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	235	0	903	0.00	1.13	26.00
26.01	RURAL HEALTH CLINIC II	657	0	2,753	0.00	5.20	26.01
26.02	RURAL HEALTH CLINIC III	1,799	0	4,760	0.00	6.62	26.02
26.03	RURAL HEALTH CLINIC IV	841	0	4,222	0.00	6.36	26.03
26.04	RURAL HEALTH CLINIC V	2,835	0	10,389	0.00	9.30	26.04
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	2,007.03	27.00
28.00	Observation Bed Days		1,112	6,557			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	154	381			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: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/25/2019 9:04 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,837	996	5,844	1.00
2.00 HMO and other (see instructions)			512	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	2,837	996	5,844	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	235	468	978	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY	0.00					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
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
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
26.04 RURAL HEALTH CLINIC V	0.00					26.04
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: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/25/2019 9:04 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	149,459,390	0	149,459,390	4,174,617.00	35.80
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		1,951,272	0	1,951,272	18,570.00	105.08
4.00	Physician-Part A - Administrative		40,000	0	40,000	192.59	207.70
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		21,159,200	0	21,159,200	79,410.00	266.46
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		691,964	0	691,964	10,611.00	65.21
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		52,792,656	-24,001	52,768,655	204,087.00	258.56
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		29,341,931	0	29,341,931		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		10,425,294	0	10,425,294		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		479,070	0	479,070		
22.00	Physician Part A - Administrative		9,033	0	9,033		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		2,877,335	0	2,877,335		
24.00	Wage-related costs (RHC/FQHC)		114,555	0	114,555		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	773,834	0	773,834	21,470.00	36.04
27.00	Administrative & General	5.00	13,105,939	0	13,105,939	429,472.00	30.52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/25/2019 9:04 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	697,295	0	697,295	2,475.65	281.66	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,314,067	0	1,314,067	51,670.00	25.43	30.00
31.00	Laundry & Linen Service	31,613	0	31,613	2,112.00	14.97	31.00
32.00	Housekeeping	1,642,596	0	1,642,596	97,393.00	16.87	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	1,566,748	-1,133,386	433,362	26,939.00	16.09	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	1,133,386	1,133,386	70,454.00	16.09	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,810,686	0	1,810,686	55,270.00	32.76	38.00
39.00	Central Services and Supply	656,913	0	656,913	39,998.00	16.42	39.00
40.00	Pharmacy	1,735,103	0	1,735,103	43,997.00	39.44	40.00
41.00	Medical Records & Medical Records Library	1,559,193	0	1,559,193	70,037.00	22.26	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/25/2019 9:04 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	126,354,249	0	126,354,249	4,068,501.65	31.06	1.00
2.00	Excluded area salaries (see instructions)	52,792,656	-24,001	52,768,655	204,087.00	258.56	2.00
3.00	Subtotal salaries (line 1 minus line 2)	73,561,593	24,001	73,585,594	3,864,414.65	19.04	3.00
4.00	Subtotal other wages & related costs (see inst.)	0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)	29,350,964	0	29,350,964	0.00	39.89	5.00
6.00	Total (sum of lines 3 thru 5)	102,912,557	24,001	102,936,558	3,864,414.65	26.64	6.00
7.00	Total overhead cost (see instructions)	24,893,987	0	24,893,987	911,287.65	27.32	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/25/2019 9:04 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		6,839,481	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		66,278	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		24,220,772	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		921,262	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		352,587	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		33,972	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		294,429	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,389,294	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		8,641,158	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		65,222	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		422,763	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		43,247,218	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	43,247,218	1.00
2.00	Hospital	0	40,420,210	2.00
3.00	Subprovider - IPF	0	1,050,679	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	1,168,008	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	493,766	13.00
14.00	Hospital-Based Health Clinic RHC	0	348	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	41,985	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	72,222	14.04
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		SARAH BUSH LINCOLN HEALTH CENTER			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0189 Component CCN: 14-7594		Period: From 07/01/2018 To 06/30/2019 Worksheet S-4 Date/Time Prepared: 11/25/2019 9:04 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County						
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,166.00	154.00	678.00	0.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			2.00	0.00	2.00	4.00
5.00	Other Administrative Personnel			12.74	0.00	12.74	5.00
6.00	Direct Nursing Service			27.25	0.00	27.25	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			7.29	0.00	7.29	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.95	0.00	2.95	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.34	0.00	0.34	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.96	0.00	0.96	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			2.28	0.00	2.28	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.			2			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
20.01				16580			20.01
		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	7,677	2,952	402	270	11,301	21.00
22.00	Skilled Nursing Visit Charges	1,384,103	527,136	79,712	49,186	2,040,137	22.00
23.00	Physical Therapy Visits	3,637	485	113	151	4,386	23.00
24.00	Physical Therapy Visit Charges	680,722	88,453	21,603	28,519	819,297	24.00
25.00	Occupational Therapy Visits	1,423	273	29	68	1,793	25.00
26.00	Occupational Therapy Visit Charges	260,877	49,686	5,278	12,498	328,339	26.00
27.00	Speech Pathology Visits	142	28	1	1	172	27.00
28.00	Speech Pathology Visit Charges	26,210	5,096	182	182	31,670	28.00
29.00	Medical Social Service Visits	139	42	3	5	189	29.00
30.00	Medical Social Service Visit Charges	30,997	9,366	669	1,115	42,147	30.00
31.00	Home Health Aide Visits	1,244	599	7	47	1,897	31.00
32.00	Home Health Aide Visit Charges	97,032	46,722	546	3,666	147,966	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	14,262	4,379	555	542	19,738	33.00
34.00	Other Charges	213,121	155,131	24,554	8,786	401,592	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,693,062	881,590	132,544	103,952	3,811,148	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,126		189	30	1,345	36.00
37.00	Total Number of Outlier Episodes		139		15	154	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

Health Financial Systems		SARAH BUSH LINCOLN HEALTH CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0189 Component CCN: 14-3978		Period: From 07/01/2018 To 06/30/2019 Worksheet S-8 Date/Time Prepared: 11/25/2019 9:04 am	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification		412 NW 3RD		1.00
	Street	City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		CASEY	IL 62420	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		07:30	16:30	07:30
			1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				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	
			1.00	2.00	
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		CLARK		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	16:30	07:30	16:30	07:30
				16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189

Period:

Worksheet S-8

Component CCN: 14-3978

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

Date/Time Prepared:

11/25/2019 9:04 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	07:30	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0189 Component CCN: 14-3998		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/25/2019 9:04 am		
				RHC II		Cost				
				1.00						
Clinic Address and Identification										
1.00	Street				7 HAWTHORNE LANE				1.00	
				City	State	ZIP Code				
				1.00	2.00	3.00				
2.00	City, State, ZIP Code, County				SULLIVAN		IL 61951		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		11.00	
				1.00		2.00				
12.00	Have you received an approval for an exception to the productivity standard?								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				MOULTRIE				2.00	
				Tuesday	Wednesday		Thursday			
				to	from	to	from	to		
				6.00	7.00	8.00	9.00	10.00		
Facility hours of operations (1)										
11.00	CLINIC				17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0189 Component CCN: 14-3998	Period: From 07/01/2018 To 06/30/2019	Worksheet S-8 Date/Time Prepared: 11/25/2019 9:04 am	
			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	08:00	17:00			11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-0189
 Component CCN: 14-3435

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

Worksheet S-8

 Date/Time Prepared:
 11/25/2019 9:04 am

				RHC III		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			650 OAK AVENUE			1.00
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			NEOGA IL 62447		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			08:30	17:30	08:30	11.00
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?					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			CUMBERLAND		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			17:30	08:30	17:30	08:30
				17:30	08:30	17:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189

Period:

Worksheet S-8

Component CCN: 14-3435

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

Date/Time Prepared:

11/25/2019 9:04 am

		RHC III		Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
Facility hours of operations (1)					
11.00	CLINIC	08:30	17:30		11.00

Health Financial Systems		SARAH BUSH LINCOLN HEALTH CENTER		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0189 Component CCN: 14-8541		Period: From 07/01/2018 To 06/30/2019 Worksheet S-8 Date/Time Prepared: 11/25/2019 9:04 am		
		RHC IV		Cost		
		1.00				
1.00	Clinic Address and Identification					
	Street	910 SOUTH VAN BUREN ST				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	NEWTON		IL 62448		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	07:00		17:00		07:00 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.					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	JASPER				2.00
		Tuesday	Wednesday	Thursday		
		to	from to	from to	to	
		6.00	7.00 8.00	9.00	10.00	
Facility hours of operations (1)						
11.00	CLINIC	17:00	07:00	17:00	07:00	17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189

Period:

Worksheet S-8

Component CCN: 14-8541

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

Date/Time Prepared:

11/25/2019 9:04 am

RHC IV

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	07:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0189 Component CCN: 14-8555		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/25/2019 9:04 am	
				RHC V		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				890 E RIDGELAWN RD		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				MARTINSVILLE		IL 62442		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?								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		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				CLARK				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	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0189

Period:

Worksheet S-8

Component CCN: 14-8555

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

Date/Time Prepared:

11/25/2019 9:04 am

RHC V

Cost

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0189

Period:

Worksheet S-9

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019PARTS I THROUGH IV
Date/Time Prepared:
11/25/2019 9:04 am

		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	0	10.00
11.00	Hospice Routine Home Care	19,516	93	1,052	20,661	11.00
12.00	Hospice Inpatient Respite Care	69	0	13	82	12.00
13.00	Hospice General Inpatient Care	59	0	9	68	13.00
14.00	Total Hospice Days	19,644	93	1,074	20,811	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: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/25/2019 9:04 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.238880		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		13,989,957		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		6,213,560		5.00
6.00	Medicaid charges		152,678,265		6.00
7.00	Medicaid cost (line 1 times line 6)		36,471,784		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)		16,268,267		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)		16,268,267		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)	5,497,206	4,163,462	9,660,668	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,313,173	4,163,462	5,476,635	21.00
22.00	Payments received from patients for amounts previously written off as charity care	61,653	264,628	326,281	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,251,520	3,898,834	5,150,354	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)		10,936,964		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		995,635		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,531,746		27.01
28.00	Non-Medicare bad debt expense (see instructions)		9,405,218		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,782,829		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,933,183		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		24,201,450		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0189

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

Worksheet A

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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		0	0	8,902,127	8,902,127	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	14,534,448	14,534,448	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	773,834	34,807,783	35,581,617	224,577	35,806,194	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,105,939	52,365,888	65,471,827	-24,714,766	40,757,061	5.00
7.00	00700	OPERATION OF PLANT	1,314,067	3,808,329	5,122,396	-26,696	5,095,700	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,613	627,458	659,071	0	659,071	8.00
9.00	00900	HOUSEKEEPING	1,642,596	533,357	2,175,953	0	2,175,953	9.00
10.00	01000	DIETARY	1,566,748	1,388,476	2,955,224	-2,137,810	817,414	10.00
11.00	01100	CAFETERIA	0	0	0	2,137,810	2,137,810	11.00
13.00	01300	NURSING ADMINISTRATION	1,810,686	522,117	2,332,803	-84,859	2,247,944	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	656,913	1,006,581	1,663,494	-7,330	1,656,164	14.00
15.00	01500	PHARMACY	1,735,103	17,011,241	18,746,344	-16,636,357	2,109,987	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,559,193	432,668	1,991,861	-7,265	1,984,596	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,259,277	2,479,277	20,738,554	-1,125,126	19,613,428	30.00
32.00	03200	CORONARY CARE UNIT	1,604,395	1,036,917	2,641,312	-1,126	2,640,186	32.00
40.00	04000	SUBPROVIDER - IPF	3,728,853	526,559	4,255,412	46,631	4,302,043	40.00
43.00	04300	NURSERY	0	16,610	16,610	499,104	515,714	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,066,129	3,581,232	9,647,361	-267,004	9,380,357	50.00
51.00	05100	RECOVERY ROOM	1,526,198	368,793	1,894,991	-14,051	1,880,940	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	81,166	81,166	757,421	838,587	52.00
53.00	05300	ANESTHESIOLOGY	5,679,190	1,428,234	7,107,424	105,718	7,213,142	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,049,771	2,047,004	9,096,775	-448,654	8,648,121	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,700,325	899,607	3,599,932	22,403	3,622,335	55.00
56.00	05600	RADIOISOTOPE	1,351,593	1,262,488	2,614,081	287,233	2,901,314	56.00
57.00	05700	CT SCAN	496,715	524,843	1,021,558	100,999	1,122,557	57.00
58.00	05800	MRI	355,400	531,574	886,974	93,382	980,356	58.00
59.00	05900	CARDIAC CATHETERIZATION	620,249	445,838	1,066,087	-6,092	1,059,995	59.00
60.00	06000	LABORATORY	5,310,332	5,524,263	10,834,595	27,672	10,862,267	60.00
65.00	06500	RESPIRATORY THERAPY	1,204,718	503,254	1,707,972	-2,311	1,705,661	65.00
66.00	06600	PHYSICAL THERAPY	3,077,907	1,645,174	4,723,081	-18,847	4,704,234	66.00
67.00	06700	OCCUPATIONAL THERAPY	504,588	58,254	562,842	0	562,842	67.00
68.00	06800	SPEECH PATHOLOGY	787,335	622,546	1,409,881	-767	1,409,114	68.00
69.00	06900	ELECTROCARDIOLOGY	1,463,434	3,058,193	4,521,627	-5,369	4,516,258	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,571,293	1,509,748	3,081,041	26,796	3,107,837	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,197,634	4,197,634	0	4,197,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,719,481	8,719,481	0	8,719,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,448,861	16,448,861	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	663,485	60,905	724,390	-18,948	705,442	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	68,520	38,177	106,697	25,080	131,777	88.00
88.01	08801	RURAL HEALTH CLINIC II	320,562	101,794	422,356	5,606	427,962	88.01
88.02	08802	RURAL HEALTH CLINIC III	618,475	96,315	714,790	10,255	725,045	88.02
88.03	08803	RURAL HEALTH CLINIC IV	409,091	124,088	533,179	5,538	538,717	88.03
88.04	08805	RURAL HEALTH CLINIC V	1,002,082	201,509	1,203,591	-206	1,203,385	88.04
91.00	09100	EMERGENCY	9,758,978	2,493,608	12,252,586	333,359	12,585,945	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,822,705	837,380	4,660,085	-8,452	4,651,633	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,618,210	970,853	2,589,063	-2,652	2,586,411	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	105,836,502	158,497,216	264,333,718	-939,668	263,394,050	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,784,741	9,113,888	47,898,629	1,166,608	49,065,237	192.00
194.00	07950	WELLNESS	456,528	153,955	610,483	-4,541	605,942	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	1,343,065	1,966,627	3,309,692	-2,830	3,306,862	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	676,014	177,710	853,724	-216,571	637,153	194.03
194.05	07954	MISC. NONREIMBURSABLE	2,362,540	6,663,071	9,025,611	-2,998	9,022,613	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	149,459,390	176,572,467	326,031,857	0	326,031,857	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0189

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

Worksheet A

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,733,590	7,168,537	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	14,534,448	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-370,502	35,435,692	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,261,126	32,495,935	5.00
7.00	00700	OPERATION OF PLANT	-114,481	4,981,219	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	659,071	8.00
9.00	00900	HOUSEKEEPING	-2,362	2,173,591	9.00
10.00	01000	DIETARY	0	817,414	10.00
11.00	01100	CAFETERIA	-947,014	1,190,796	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,247,944	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,656,164	14.00
15.00	01500	PHARMACY	0	2,109,987	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-54,317	1,930,279	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-4,111,446	15,501,982	30.00
32.00	03200	CORONARY CARE UNIT	0	2,640,186	32.00
40.00	04000	SUBPROVIDER - IPF	-1,798,755	2,503,288	40.00
43.00	04300	NURSERY	0	515,714	43.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	9,380,357	50.00
51.00	05100	RECOVERY ROOM	0	1,880,940	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	838,587	52.00
53.00	05300	ANESTHESIOLOGY	-6,591,134	622,008	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-4,107,335	4,540,786	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,345,402	2,276,933	55.00
56.00	05600	RADIOISOTOPE	0	2,901,314	56.00
57.00	05700	CT SCAN	0	1,122,557	57.00
58.00	05800	MRI	0	980,356	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,059,995	59.00
60.00	06000	LABORATORY	-937,839	9,924,428	60.00
65.00	06500	RESPIRATORY THERAPY	-152,107	1,553,554	65.00
66.00	06600	PHYSICAL THERAPY	-166	4,704,068	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	562,842	67.00
68.00	06800	SPEECH PATHOLOGY	-921,050	488,064	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,920,242	1,596,016	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-683,542	2,424,295	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,197,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,719,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,448,861	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	705,442	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	131,777	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	427,962	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	725,045	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	538,717	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,203,385	88.04
91.00	09100	EMERGENCY	-6,684,191	5,901,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	4,651,633	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	2,586,411	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-41,736,601	221,657,449	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,065,237	192.00
194.00	07950	WELLNESS	0	605,942	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	3,306,862	194.01
194.02	07951	LIFELINE	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	637,153	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	9,022,613	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-41,736,601	284,295,256	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet Non-CMS W
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
32.00	CORONARY CARE UNIT	03200		32.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
45.00	NURSING FACILITY	04500		45.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00	RADIOLOGY-THERAPEUTIC	05500		55.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
75.00	ASC (NON-DISTINCT PART)	07500		75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	RURAL HEALTH CLINIC II	08801		88.01
88.02	RURAL HEALTH CLINIC III	08802		88.02
88.03	RURAL HEALTH CLINIC IV	08803		88.03
88.04	RURAL HEALTH CLINIC V	08805		88.04
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	WELLNESS	07950		194.00
194.01	OTHER NONREIMB PROGRAM: PEACE MEAL	07953		194.01
194.02	LIFELINE	07951		194.02
194.03	OCCUPATIONAL HEALTH	07952		194.03
194.05	MISC. NONREIMBURSABLE	07954		194.05
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0189

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

Worksheet A-6

Date/Time Prepared:
11/25/2019 9:04 am

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
A - DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	16,448,861	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
0			0	16,448,861		
B - RADIOLOGY ADMIN EXPENSE ALLOCATION						
1.00	RADIOISOTOPE	56.00	174,305	112,928	1.00	
2.00	CT SCAN	57.00	64,058	46,946	2.00	
3.00	MRI	58.00	45,833	47,549	3.00	
0			284,196	207,423		
C - CAP REL COSTS-MOVABLE EQUIP						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	830,054	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
0			0	830,054		
D - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,957,371	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	13,704,394	2.00	
0			0	20,661,765		
E - CAFETERIA EXPENSE						
1.00	CAFETERIA	11.00	1,133,386	1,004,424	1.00	
0			1,133,386	1,004,424		
F - EMPLOYEE PHYSICALS/BENF EXP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	214,911	1.00	
0			0	214,911		
G - EAP BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,968	1.00	
0			0	15,968		
H - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,944,756	1.00	
0			0	1,944,756		
I - NURSRY/L&D EXP						
1.00	NURSERY	43.00	499,104	0	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	757,421	0	2.00	
0			1,256,525	0		
J - PHYSN PROF LIAB EXP						
1.00	ADULTS & PEDIATRICS	30.00	0	156,299	1.00	
2.00	SUBPROVIDER - IPF	40.00	0	50,018	2.00	
3.00	ANESTHESIOLOGY	53.00	0	112,557	3.00	
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	25,009	4.00	

RECLASSIFICATIONS

Provider CCN: 14-0189

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

Worksheet A-6

Date/Time Prepared:
11/25/2019 9:04 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
5.00	LABORATORY	60.00	0	15,627	5.00
7.00	EMERGENCY	91.00	0	337,702	7.00
8.00	RURAL HEALTH CLINIC	88.00	0	1,046	8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	6,279	9.00
10.00	RURAL HEALTH CLINIC III	88.02	0	10,988	10.00
11.00	RURAL HEALTH CLINIC IV	88.03	0	6,279	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,234,429	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	46,896	13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	35,433	14.00
15.00	RURAL HEALTH CLINIC V	88.04	0	18,837	15.00
	0		0	2,057,399	
K - RHC V-LAB STAFF EXPENSE					
1.00	LABORATORY	60.00	17,160	986	1.00
	0		17,160	986	
L - RHC S&W RECLASS-TOL TO CASEY					
1.00	RURAL HEALTH CLINIC	88.00	24,001	348	1.00
	0		24,001	348	
500.00	Grand Total: Increases		2,715,268	43,386,895	500.00

RECLASSIFICATIONS

Provider CCN: 14-0189

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

Worksheet A-6

Date/Time Prepared:
11/25/2019 9:04 am

	Decreases					11/25/2019 9:04 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	16,420,077	0	1.00
2.00	RECOVERY ROOM	51.00	0	11,851	0	2.00
3.00	ANESTHESIOLOGY	53.00	0	6,839	0	3.00
4.00	CT SCAN	57.00	0	10,005	0	4.00
5.00	OPERATING ROOM	50.00	0	89	0	5.00
0			0	16,448,861		
B - RADIOLOGY ADMIN EXPENSE ALLOCATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	284,196	207,423	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
0			284,196	207,423		
C - CAP REL COSTS-MOVABLE EQUIP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,302	14	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	50,846	14	2.00
3.00	OPERATION OF PLANT	7.00	0	26,696	14	3.00
4.00	NURSING ADMINISTRATION	13.00	0	84,859	14	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,330	14	5.00
6.00	PHARMACY	15.00	0	216,280	14	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,265	14	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	24,900	14	8.00
9.00	CORONARY CARE UNIT	32.00	0	1,126	14	9.00
10.00	SUBPROVIDER - IPF	40.00	0	3,387	14	10.00
12.00	OPERATING ROOM	50.00	0	266,915	14	12.00
13.00	RECOVERY ROOM	51.00	0	2,200	14	13.00
14.00	RURAL HEALTH CLINIC IV	88.03	0	741	14	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,931	14	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,606	14	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	6,092	14	17.00
18.00	LABORATORY	60.00	0	6,101	14	18.00
19.00	RESPIRATORY THERAPY	65.00	0	2,311	14	19.00
20.00	PHYSICAL THERAPY	66.00	0	18,847	14	20.00
21.00	SPEECH PATHOLOGY	68.00	0	767	14	21.00
22.00	ELECTROCARDIOLOGY	69.00	0	5,369	14	22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,637	14	23.00
24.00	RURAL HEALTH CLINIC	88.00	0	315	14	24.00
25.00	RURAL HEALTH CLINIC II	88.01	0	673	14	25.00
26.00	RURAL HEALTH CLINIC III	88.02	0	733	14	26.00
27.00	EMERGENCY	91.00	0	4,343	14	27.00
28.00	HOME HEALTH AGENCY	101.00	0	8,452	14	28.00
29.00	HOSPICE	116.00	0	2,652	14	29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43,472	14	30.00
31.00	WELLNESS	194.00	0	4,541	14	31.00
32.00	OCCUPATIONAL HEALTH	194.03	0	1,660	14	32.00
33.00	MISC. NONREIMBURSABLE	194.05	0	2,998	14	33.00
34.00	OTHER NONREIMB PROGRAM:	194.01	0	2,830	14	34.00
	PEACE MEAL					
35.00	RURAL HEALTH CLINIC V	88.04	0	897	14	35.00
36.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	2,980	14	36.00
0			0	830,054		
D - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,661,765	9	1.00
2.00		0.00	0	0	9	2.00
0			0	20,661,765		
E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	1,133,386	1,004,424	0	1.00
0			1,133,386	1,004,424		
F - EMPLOYEE PHYSICALS/BENF EXP						
1.00	OCCUPATIONAL HEALTH	194.03	0	214,911	0	1.00
0			0	214,911		
G - EAP BENEFITS						
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	15,968	0	1.00
0			0	15,968		
H - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,944,756	11	1.00
0			0	1,944,756		
I - NURSRY/L&D EXP						
1.00	ADULTS & PEDIATRICS	30.00	1,256,525	0	0	1.00
2.00		0.00	0	0	0	2.00
0			1,256,525	0		

RECLASSIFICATIONS

Provider CCN: 14-0189

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

Worksheet A-6

Date/Time Prepared:
11/25/2019 9:04 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
J - PHYSN PROF LIAB EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,057,399	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
	0		0	2,057,399		
K - RHC V-LAB STAFF EXPENSE						
1.00	RURAL HEALTH CLINIC V	88.04	17,160	986	0	1.00
	0		17,160	986		
L - RHC S&W RECLASS-TOL TO CASEY						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	24,001	348	0	1.00
	0		24,001	348		
500.00	Grand Total: Decreases		2,715,268	43,386,895		500.00

RECLASSIFICATIONS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/25/2019 9:04 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - DRUGS CHARGED TO PATIENTS									
1.00 DRUGS CHARGED TO PATIENTS	73.00	0	16,448,861		PHARMACY	15.00	0	16,420,077	1.00
2.00	0.00	0	0		RECOVERY ROOM	51.00	0	11,851	2.00
3.00	0.00	0	0		ANESTHESIOLOGY	53.00	0	6,839	3.00
4.00	0.00	0	0		CT SCAN	57.00	0	10,005	4.00
5.00	0.00	0	0		OPERATING ROOM	50.00	0	89	5.00
0		0	16,448,861	0			0	16,448,861	
B - RADIOLOGY ADMIN EXPENSE ALLOCATION									
1.00 RADIOISOTOPE	56.00	174,305	112,928		RADIOLOGY-DIAGNOSTIC	54.00	284,196	207,423	1.00
2.00 CT SCAN	57.00	64,058	46,946			0.00	0	0	2.00
3.00 MRI	58.00	45,833	47,549			0.00	0	0	3.00
0		284,196	207,423	0			284,196	207,423	
C - CAP REL COSTS-MOVABLE EQUIP									
1.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	830,054		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,302	1.00
2.00	0.00	0	0		ADMINISTRATIVE & GENERAL	5.00	0	50,846	2.00
3.00	0.00	0	0		OPERATION OF PLANT	7.00	0	26,696	3.00
4.00	0.00	0	0		NURSING	13.00	0	84,859	4.00
5.00	0.00	0	0		ADMINISTRATION	14.00	0	7,330	5.00
6.00	0.00	0	0		CENTRAL SERVICES & SUPPLY	15.00	0	216,280	6.00
7.00	0.00	0	0		PHARMACY	16.00	0	7,265	7.00
8.00	0.00	0	0		MEDICAL RECORDS & LIBRARY	30.00	0	24,900	8.00
9.00	0.00	0	0		ADULTS & PEDIATRICS	32.00	0	1,126	9.00
10.00	0.00	0	0		CORONARY CARE UNIT	40.00	0	3,387	10.00
12.00	0.00	0	0		SUBPROVIDER - IPF	50.00	0	266,915	12.00
13.00	0.00	0	0		OPERATING ROOM	51.00	0	2,200	13.00
14.00	0.00	0	0		RECOVERY ROOM	88.03	0	741	14.00
15.00	0.00	0	0		RURAL HEALTH CLINIC IV	54.00	0	3,931	15.00
16.00	0.00	0	0		RADIOLOGY-DIAGNOSTIC	55.00	0	2,606	16.00
17.00	0.00	0	0		RADIOLOGY-THERAPEUTIC	59.00	0	6,092	17.00
18.00	0.00	0	0		CARDIAC CATHETERIZATION	60.00	0	6,101	18.00
19.00	0.00	0	0		LABORATORY	65.00	0	2,311	19.00
20.00	0.00	0	0		RESPIRATORY THERAPY	66.00	0	18,847	20.00
21.00	0.00	0	0		PHYSICAL THERAPY	68.00	0	767	21.00
22.00	0.00	0	0		SPEECH PATHOLOGY	69.00	0	5,369	22.00
23.00	0.00	0	0		ELECTROCARDIOLOGY	70.00	0	8,637	23.00
24.00	0.00	0	0		ELECTROENCEPHALOGRAPH Y	88.00	0	315	24.00
25.00	0.00	0	0		RURAL HEALTH CLINIC II	88.01	0	673	25.00
26.00	0.00	0	0		RURAL HEALTH CLINIC III	88.02	0	733	26.00
27.00	0.00	0	0		EMERGENCY	91.00	0	4,343	27.00
28.00	0.00	0	0		HOME HEALTH AGENCY	101.00	0	8,452	28.00
29.00	0.00	0	0		HOSPICE	116.00	0	2,652	29.00
30.00	0.00	0	0		PHYSICIANS' PRIVATE OFFICES	192.00	0	43,472	30.00
31.00	0.00	0	0		WELLNESS	194.00	0	4,541	31.00
32.00	0.00	0	0		OCCUPATIONAL HEALTH	194.03	0	1,660	32.00
33.00	0.00	0	0		MISC. NONREIMBURSABLE	194.05	0	2,998	33.00
34.00	0.00	0	0		OTHER NONREIMB	194.01	0	2,830	34.00
35.00	0.00	0	0		PROGRAM: PEACE MEAL	88.04	0	897	35.00
36.00	0.00	0	0		RURAL HEALTH CLINIC V	76.00	0	2,980	36.00
0		0	830,054	0	PSYCHIATRIC/PSYCHOLOG ICAL SERVICES		0	830,054	
D - DEPRECIATION									
1.00 CAP REL COSTS-BLDG & FIXT	1.00	0	6,957,371		ADMINISTRATIVE & GENERAL	5.00	0	20,661,765	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	13,704,394			0.00	0	0	2.00
0		0	20,661,765	0			0	20,661,765	
E - CAFETERIA EXPENSE									
1.00 CAFETERIA	11.00	1,133,386	1,004,424		DIETARY	10.00	1,133,386	1,004,424	1.00
0		1,133,386	1,004,424	0			1,133,386	1,004,424	

RECLASSIFICATIONS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/25/2019 9:04 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
F - EMPLOYEE PHYSICALS/BENF EXP									
1.00	EMPLOYEE BENEFITS	4.00	0	214,911	OCCUPATIONAL HEALTH	194.03	0	214,911	1.00
	DEPARTMENT								
	0		0	214,911	0		0	214,911	
G - EAP BENEFITS									
1.00	EMPLOYEE BENEFITS	4.00	0	15,968	PSYCHIATRIC/PSYCHOLOG	76.00	0	15,968	1.00
	DEPARTMENT				ICAL SERVICES				
	0		0	15,968	0		0	15,968	
H - INTEREST EXPENSE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,944,756	ADMINISTRATIVE & GENERAL	5.00	0	1,944,756	1.00
	0		0	1,944,756	0		0	1,944,756	
I - NURSRY/L&D EXP									
1.00	NURSERY	43.00	499,104	0	ADULTS & PEDIATRICS	30.00	1,256,525	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	757,421	0		0.00	0	0	2.00
	0		1,256,525	0	0		1,256,525	0	
J - PHYSN PROF LIAB EXP									
1.00	ADULTS & PEDIATRICS	30.00	0	156,299	ADMINISTRATIVE & GENERAL	5.00	0	2,057,399	1.00
2.00	SUBPROVIDER - IPF	40.00	0	50,018		0.00	0	0	2.00
3.00	ANESTHESIOLOGY	53.00	0	112,557		0.00	0	0	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	25,009		0.00	0	0	4.00
5.00	LABORATORY	60.00	0	15,627		0.00	0	0	5.00
7.00	EMERGENCY	91.00	0	337,702		0.00	0	0	7.00
8.00	RURAL HEALTH CLINIC	88.00	0	1,046		0.00	0	0	8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	6,279		0.00	0	0	9.00
10.00	RURAL HEALTH CLINIC III	88.02	0	10,988		0.00	0	0	10.00
11.00	RURAL HEALTH CLINIC IV	88.03	0	6,279		0.00	0	0	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,234,429		0.00	0	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	46,896		0.00	0	0	13.00
14.00	ELECTROENCEPHALOGRAPH Y	70.00	0	35,433		0.00	0	0	14.00
15.00	RURAL HEALTH CLINIC V	88.04	0	18,837		0.00	0	0	15.00
	0		0	2,057,399	0		0	2,057,399	
K - RHC V-LAB STAFF EXPENSE									
1.00	LABORATORY	60.00	17,160	986	RURAL HEALTH CLINIC V	88.04	17,160	986	1.00
	0		17,160	986	0		17,160	986	
L - RHC S&W RECLASS-TOL TO CASEY									
1.00	RURAL HEALTH CLINIC	88.00	24,001	348	PHYSICIANS' PRIVATE OFFICES	192.00	24,001	348	1.00
	0		24,001	348	0		24,001	348	
500.00	Grand Total: Increases		2,715,268	43,386,895	Grand Total: Decreases		2,715,268	43,386,895	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/25/2019 9:04 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	3,677,396	134,250	0	134,250	0	1.00	
2.00	Land Improvements	14,062,953	1,088,483	0	1,088,483	0	2.00	
3.00	Buildings and Fixtures	164,558,901	28,897,512	0	28,897,512	281,295	3.00	
4.00	Building Improvements	270,012	16,441	0	16,441	0	4.00	
5.00	Fixed Equipment	18,849,298	2,056,776	0	2,056,776	0	5.00	
6.00	Movable Equipment	119,364,200	13,228,493	0	13,228,493	1,641,434	6.00	
7.00	HIT designated Assets	684,552	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	321,467,312	45,421,955	0	45,421,955	1,922,729	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	321,467,312	45,421,955	0	45,421,955	1,922,729	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	3,811,646	0					1.00
2.00	Land Improvements	15,151,436	0					
3.00	Buildings and Fixtures	193,175,118	0					
4.00	Building Improvements	286,453	0					4.00
5.00	Fixed Equipment	20,906,074	0					
6.00	Movable Equipment	130,951,259	0					
7.00	HIT designated Assets	684,552	0					7.00
8.00	Subtotal (sum of lines 1-7)	364,966,538	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	364,966,538	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/25/2019 9:04 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	6,730,129	0	6,730,129	0.317047	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,497,415	0	14,497,415	0.682953	0	2.00
3.00	Total (sum of lines 1-2)	21,227,544	0	21,227,544	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	6,957,371	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,704,394	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,661,765	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	211,166	0	0	0	7,168,537	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	830,054	14,534,448	2.00
3.00	Total (sum of lines 1-2)	211,166	0	0	830,054	21,702,985	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0189

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

Worksheet A-8

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-27,032,320			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-901,574	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-113,581	OPERATION OF PLANT	7.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-54,317	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	-2,362	HOUSEKEEPING	9.00	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVESTMENT INCOME	B	-1,733,590	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0189

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

Worksheet A-8

Date/Time Prepared:
11/25/2019 9:04 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
35.00 A&G OTHER INCOME	B	-325,855	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 SURG/PAIN MISC REV	B	0	RADIOLOGY-THERAPEUTIC	55.00	0	36.00
37.00 FACILITIES SVC OTHER REV	B	-900	OPERATION OF PLANT	7.00	0	37.00
38.00 W&C (BABY CLASSES), 4W MISC	B	-2,668	ADULTS & PEDIATRICS	30.00	0	38.00
38.01 XRAY OTHER REVENUE	B	-295	RADIOLOGY-DIAGNOSTIC	54.00	0	38.01
39.00 PHYSICAL THERAPY OTHER REV	B	-166	PHYSICAL THERAPY	66.00	0	39.00
39.01 MEDICAID ASSESSMENT TAX	A	-7,902,643	ADMINISTRATIVE & GENERAL	5.00	0	39.01
41.00 SPEECH/AUDIO OTHER REV	B	-921,050	SPEECH PATHOLOGY	68.00	0	41.00
42.00 METS/REHAB MISC REV	B	-75,898	ELECTROCARDIOLOGY	69.00	0	42.00
43.00 EMERGENCY (EMS)OTHER REV	B	-160,972	EMERGENCY	91.00	0	43.00
44.00 AHA/IIHA LOBBYING FEES	A	-32,628	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 CRNA S&W (EMPLOYEEES)	A	-2,059,840	ANESTHESIOLOGY	53.00	0	45.00
45.01 CRNA (BENEFIT EXP)	A	-370,502	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02 CAFETERIA REV/OTHER	B	-45,440	CAFETERIA	11.00	0	45.02
45.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-41,736,601				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0189

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

Worksheet A-8-2

Date/Time Prepared:
11/25/2019 9:04 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	4,108,778	4,108,778	0	142,500	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	1,798,755	1,798,755	0	138,700	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	4,531,294	4,531,294	0	167,500	0	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	4,107,040	4,107,040	0	167,500	0	4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	1,345,402	1,345,402	0	217,600	0	5.00
6.00	60.00	DR. A	937,839	937,839	0	208,000	0	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	152,107	152,107	0	159,800	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	2,844,344	2,844,344	0	159,800	0	8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	683,542	683,542	0	159,800	0	9.00
10.00	91.00	DR. B	523,436	483,436	40,000	159,800	193	10.00
11.00	91.00	AGGREGATE-EMERGENCY	6,015,808	6,015,808	0	159,800	0	11.00
200.00			27,048,345	27,008,345	40,000		193	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	44,090	0	156,299	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	18,393	0	50,018	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	33,523	0	112,557	3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	17,423	0	46,896	4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	13,428	0	25,009	5.00
6.00	60.00	DR. A	0	0	4,369	0	15,627	6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	4,172	0	23,969	9.00
10.00	91.00	DR. B	14,828	741	3,254	249	12,407	10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	46,830	0	325,295	11.00
200.00			14,828	741	185,482	249	768,077	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	4,108,778		1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	1,798,755		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	4,531,294		3.00
4.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	4,107,040		4.00
5.00	55.00	AGGREGATE-RADIOLOGY-THERAPEUTIC	0	0	0	1,345,402		5.00
6.00	60.00	DR. A	0	0	0	937,839		6.00
7.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	152,107		7.00
8.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	2,844,344		8.00
9.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	683,542		9.00
10.00	91.00	DR. B	948	16,025	23,975	507,411		10.00
11.00	91.00	AGGREGATE-EMERGENCY	0	0	0	6,015,808		11.00
200.00			948	16,025	23,975	27,032,320		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 9:04 am

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	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	7,168,537	7,168,537			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	14,534,448	14,534,448			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	35,435,692	44,711	3,392	35,483,795	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,495,935	556,173	5,913,749	3,127,732	5.00
7.00	00700	OPERATION OF PLANT	4,981,219	436,585	475,764	313,602	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	659,071	12,981	0	7,544	8.00
9.00	00900	HOUSEKEEPING	2,173,591	31,681	19,521	392,006	9.00
10.00	01000	DIETARY	817,414	80,230	17,005	103,422	10.00
11.00	01100	CAFETERIA	1,190,796	48,561	44,474	270,483	11.00
13.00	01300	NURSING ADMINISTRATION	2,247,944	24,653	101,453	432,120	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,656,164	81,550	316,963	156,772	14.00
15.00	01500	PHARMACY	2,109,987	35,874	34,184	414,082	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,930,279	47,107	28,666	372,101	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,501,982	810,370	948,356	4,057,707	30.00
32.00	03200	CORONARY CARE UNIT	2,640,186	59,989	61,703	382,889	32.00
40.00	04000	SUBPROVIDER - IPF	2,503,288	106,546	25,632	889,891	40.00
43.00	04300	NURSERY	515,714	7,541	81,803	119,111	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,380,357	458,770	1,702,567	1,447,682	50.00
51.00	05100	RECOVERY ROOM	1,880,940	103,918	76,840	364,227	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	838,587	17,197	47,958	180,759	52.00
53.00	05300	ANESTHESIOLOGY	622,008	7,896	108,455	1,355,339	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,540,786	200,062	946,033	1,614,604	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,276,933	262,790	682,546	644,433	55.00
56.00	05600	RADIOISOTOPE	2,901,314	32,097	446,198	364,156	56.00
57.00	05700	CT SCAN	1,122,557	18,652	109,880	133,828	57.00
58.00	05800	MRI	980,356	24,971	149,331	95,754	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,059,995	96,670	570,114	148,022	59.00
60.00	06000	LABORATORY	9,924,428	163,247	417,445	1,271,406	60.00
65.00	06500	RESPIRATORY THERAPY	1,553,554	18,884	73,448	287,506	65.00
66.00	06600	PHYSICAL THERAPY	4,704,068	175,739	52,657	734,543	66.00
67.00	06700	OCCUPATIONAL THERAPY	562,842	5,158	416	120,420	67.00
68.00	06800	SPEECH PATHOLOGY	488,064	37,817	25,778	187,897	68.00
69.00	06900	ELECTROCARDIOLOGY	1,596,016	192,252	140,437	349,249	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,424,295	56,115	30,068	374,989	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,197,634	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,719,481	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,448,861	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	705,442	33,234	3,304	158,341	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	131,777	25,436	5,112	22,080	88.00
88.01	08801	RURAL HEALTH CLINIC II	427,962	66,504	5,056	76,502	88.01
88.02	08802	RURAL HEALTH CLINIC III	725,045	23,749	13,858	147,599	88.02
88.03	08803	RURAL HEALTH CLINIC IV	538,717	26,902	4,329	97,630	88.03
88.04	08805	RURAL HEALTH CLINIC V	1,203,385	77,517	17,257	235,052	88.04
91.00	09100	EMERGENCY	5,901,754	218,079	112,406	2,328,980	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	4,651,633	48,769	4,813	912,289	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	2,586,411	18,334	623	386,186	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	221,657,449	4,795,311	13,819,594	25,078,935	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	49,065,237	1,771,999	420,019	9,250,237	192.00
194.00	07950	WELLNESS	605,942	284,791	74,536	108,950	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	3,306,862	0	132,576	320,522	194.01
194.02	07951	LIFELINE	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	637,153	35,581	8,399	161,331	194.03
194.05	07954	MISC. NONREIMBURSABLE	9,022,613	280,855	79,324	563,820	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	284,295,256	7,168,537	14,534,448	35,483,795	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	42,093,589					5.00
7.00	00700	OPERATION OF PLANT	1,078,781	7,285,951				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,111	15,426	813,133			8.00
9.00	00900	HOUSEKEEPING	454,789	37,649	38,821	3,148,058		9.00
10.00	01000	DIETARY	176,937	95,343	12,549	0	1,302,900	10.00
11.00	01100	CAFETERIA	270,134	57,708	0	94,693	0	11.00
13.00	01300	NURSING ADMINISTRATION	487,701	29,297	0	23,173	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	384,341	96,912	16,553	34,330	0	14.00
15.00	01500	PHARMACY	450,849	42,631	0	8,582	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	413,313	55,980	0	14,018	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,705,055	963,016	221,635	31,755	1,051,400	30.00
32.00	03200	CORONARY CARE UNIT	546,548	71,289	16,377	64,655	42,039	32.00
40.00	04000	SUBPROVIDER - IPF	612,693	126,616	20,789	128,737	167,186	40.00
43.00	04300	NURSERY	125,858	8,962	5,865	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,257,502	545,186	130,417	829,929	6,875	50.00
51.00	05100	RECOVERY ROOM	421,616	123,493	50,890	77,815	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,482	20,437	39,342	0	0	52.00
53.00	05300	ANESTHESIOLOGY	363,876	9,383	0	8,296	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,268,969	237,747	33,204	76,670	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	672,017	312,290	0	217,423	0	55.00
56.00	05600	RADIOISOTOPE	650,651	38,143	21,645	21,456	0	56.00
57.00	05700	CT SCAN	240,693	22,165	14,345	13,446	0	57.00
58.00	05800	MRI	217,317	29,675	4,946	12,874	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	325,833	114,879	12,187	47,204	0	59.00
60.00	06000	LABORATORY	2,046,713	193,998	115	111,858	0	60.00
65.00	06500	RESPIRATORY THERAPY	336,016	22,441	0	18,309	0	65.00
66.00	06600	PHYSICAL THERAPY	984,903	208,842	7,996	110,714	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	119,717	6,130	0	10,013	0	67.00
68.00	06800	SPEECH PATHOLOGY	128,532	44,941	160	18,595	0	68.00
69.00	06900	ELECTROCARDIOLOGY	395,899	228,466	11,169	131,312	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	501,483	66,685	708	38,907	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	729,532	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,515,411	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,858,746	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	156,472	39,494	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	32,049	30,227	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	100,111	79,031	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	158,198	28,222	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	116,022	31,970	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	266,466	92,118	0	0	0	88.04
91.00	09100	EMERGENCY	1,487,906	259,157	153,351	329,854	35,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	976,300	57,955	0	20,026	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	519,920	21,788	0	5,722	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,862,462	4,465,692	813,064	2,500,366	1,302,900	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,515,868	2,105,782	69	461,452	0	192.00
194.00	07950	WELLNESS	186,695	338,436	0	97,268	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	653,466	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	146,417	42,283	0	22,887	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	1,728,681	333,758	0	66,085	0	194.05
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)	42,093,589	7,285,951	813,133	3,148,058	1,302,900	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,976,849					11.00
13.00	01300	NURSING ADMINISTRATION	43,643	3,389,984				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	30,711	0	2,774,296			14.00
15.00	01500	PHARMACY	33,944	0	0	3,130,133		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,957	0	0	0	2,916,421	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	408,946	1,563,134	0	0	114,225	30.00
32.00	03200	CORONARY CARE UNIT	40,410	171,839	0	0	12,915	32.00
40.00	04000	SUBPROVIDER - IPF	51,725	171,097	0	0	24,393	40.00
43.00	04300	NURSERY	14,548	68,601	0	0	6,970	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	153,557	646,155	0	0	280,867	50.00
51.00	05100	RECOVERY ROOM	38,793	160,173	0	0	55,158	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,013	99,348	0	0	25,286	52.00
53.00	05300	ANESTHESIOLOGY	27,479	6,542	0	0	56,121	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	67,889	0	0	0	169,754	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	42,026	0	0	0	53,555	55.00
56.00	05600	RADIOISOTOPE	27,479	0	0	0	158,238	56.00
57.00	05700	CT SCAN	14,548	0	0	0	285,421	57.00
58.00	05800	MRI	9,698	0	0	0	100,093	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,315	0	0	0	73,489	59.00
60.00	06000	LABORATORY	153,557	0	0	0	228,221	60.00
65.00	06500	RESPIRATORY THERAPY	32,328	0	0	0	50,530	65.00
66.00	06600	PHYSICAL THERAPY	50,108	0	0	0	115,100	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,315	0	0	0	10,706	67.00
68.00	06800	SPEECH PATHOLOGY	17,780	0	0	0	12,064	68.00
69.00	06900	ELECTROCARDIOLOGY	43,643	0	0	0	34,502	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,164	0	0	0	23,800	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	887,775	0	127,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,886,521	0	133,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,130,133	476,458	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	24,246	0	0	0	796	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	348	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	1,265	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	2,202	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	2,108	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	4,799	88.04
91.00	09100	EMERGENCY	142,243	503,095	0	0	233,617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	21,013	0	0	0	20,889	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	9,698	0	0	0	21,662	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,614,776	3,389,984	2,774,296	3,130,133	2,916,421	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	315,197	0	0	0	0	192.00
194.00	07950	WELLNESS	17,780	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	14,548	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	14,548	0	0	0	0	194.05
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)	1,976,849	3,389,984	2,774,296	3,130,133	2,916,421	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,377,581	0	29,377,581	30.00
32.00	03200	CORONARY CARE UNIT	4,110,839	0	4,110,839	32.00
40.00	04000	SUBPROVIDER - IPF	4,828,593	0	4,828,593	40.00
43.00	04300	NURSERY	954,973	0	954,973	43.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,839,864	0	17,839,864	50.00
51.00	05100	RECOVERY ROOM	3,353,863	0	3,353,863	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,478,409	0	1,478,409	52.00
53.00	05300	ANESTHESIOLOGY	2,565,395	0	2,565,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,155,718	0	9,155,718	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,164,013	0	5,164,013	55.00
56.00	05600	RADIOISOTOPE	4,661,377	0	4,661,377	56.00
57.00	05700	CT SCAN	1,975,535	0	1,975,535	57.00
58.00	05800	MRI	1,625,015	0	1,625,015	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,459,708	0	2,459,708	59.00
60.00	06000	LABORATORY	14,510,988	0	14,510,988	60.00
65.00	06500	RESPIRATORY THERAPY	2,393,016	0	2,393,016	65.00
66.00	06600	PHYSICAL THERAPY	7,144,670	0	7,144,670	66.00
67.00	06700	OCCUPATIONAL THERAPY	846,717	0	846,717	67.00
68.00	06800	SPEECH PATHOLOGY	961,628	0	961,628	68.00
69.00	06900	ELECTROCARDIOLOGY	3,122,945	0	3,122,945	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,533,214	0	3,533,214	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,942,770	0	5,942,770	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,254,453	0	12,254,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,914,198	0	22,914,198	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,121,329	0	1,121,329	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	247,029	0	247,029	88.00
88.01	08801	RURAL HEALTH CLINIC II	756,431	0	756,431	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,098,873	0	1,098,873	88.02
88.03	08803	RURAL HEALTH CLINIC IV	817,678	0	817,678	88.03
88.04	08805	RURAL HEALTH CLINIC V	1,896,594	0	1,896,594	88.04
91.00	09100	EMERGENCY	11,705,842	0	11,705,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,713,687	0	6,713,687	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,570,344	0	3,570,344	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	191,103,289	0	191,103,289	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	73,905,860	0	73,905,860	192.00
194.00	07950	WELLNESS	1,714,398	0	1,714,398	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	4,413,426	0	4,413,426	194.01
194.02	07951	LIFELINE	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	1,068,599	0	1,068,599	194.03
194.05	07954	MISC. NONREIMBURSABLE	12,089,684	0	12,089,684	194.05
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	284,295,256	0	284,295,256	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0189

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

Worksheet Non-CMS W

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
1.00	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	3	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-16	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	7	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDR	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVIC	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	13	DIRECT NRSING HR	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	44,711	3,392	48,103	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	556,173	5,913,749	6,469,922	5.00
7.00	00700	OPERATION OF PLANT	0	436,585	475,764	912,349	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,981	0	12,981	8.00
9.00	00900	HOUSEKEEPING	0	31,681	19,521	51,202	9.00
10.00	01000	DIETARY	0	80,230	17,005	97,235	10.00
11.00	01100	CAFETERIA	0	48,561	44,474	93,035	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,653	101,453	126,106	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	81,550	316,963	398,513	14.00
15.00	01500	PHARMACY	0	35,874	34,184	70,058	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	47,107	28,666	75,773	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	810,370	948,356	1,758,726	30.00
32.00	03200	CORONARY CARE UNIT	0	59,989	61,703	121,692	32.00
40.00	04000	SUBPROVIDER - IPF	0	106,546	25,632	132,178	40.00
43.00	04300	NURSERY	0	7,541	81,803	89,344	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	458,770	1,702,567	2,161,337	50.00
51.00	05100	RECOVERY ROOM	0	103,918	76,840	180,758	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,197	47,958	65,155	52.00
53.00	05300	ANESTHESIOLOGY	0	7,896	108,455	116,351	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	200,062	946,033	1,146,095	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	262,790	682,546	945,336	55.00
56.00	05600	RADIOISOTOPE	0	32,097	446,198	478,295	56.00
57.00	05700	CT SCAN	0	18,652	109,880	128,532	57.00
58.00	05800	MRI	0	24,971	149,331	174,302	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	96,670	570,114	666,784	59.00
60.00	06000	LABORATORY	0	163,247	417,445	580,692	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,884	73,448	92,332	65.00
66.00	06600	PHYSICAL THERAPY	0	175,739	52,657	228,396	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,158	416	5,574	67.00
68.00	06800	SPEECH PATHOLOGY	0	37,817	25,778	63,595	68.00
69.00	06900	ELECTROCARDIOLOGY	0	192,252	140,437	332,689	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	56,115	30,068	86,183	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	33,234	3,304	36,538	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	25,436	5,112	30,548	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	66,504	5,056	71,560	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	23,749	13,858	37,607	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	26,902	4,329	31,231	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	77,517	17,257	94,774	88.04
91.00	09100	EMERGENCY	0	218,079	112,406	330,485	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	48,769	4,813	53,582	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	18,334	623	18,957	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,795,311	13,819,594	18,614,905	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,771,999	420,019	2,192,018	192.00
194.00	07950	WELLNESS	0	284,791	74,536	359,327	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	132,576	132,576	194.01
194.02	07951	LIFELINE	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	35,581	8,399	43,980	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	280,855	79,324	360,179	194.05
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,168,537	14,534,448	21,702,985	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	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	6,474,168				5.00
7.00	00700	OPERATION OF PLANT	165,918	1,078,693			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18,166	2,284	33,441		8.00
9.00	00900	HOUSEKEEPING	69,947	5,574	1,597	128,852	9.00
10.00	01000	DIETARY	27,213	14,116	516	0	10.00
11.00	01100	CAFETERIA	41,547	8,544	0	3,876	11.00
13.00	01300	NURSING ADMINISTRATION	75,009	4,337	0	948	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	59,112	14,348	681	1,405	14.00
15.00	01500	PHARMACY	69,341	6,312	0	351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,568	8,288	0	574	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	569,841	142,576	9,113	1,300	30.00
32.00	03200	CORONARY CARE UNIT	84,060	10,554	674	2,646	32.00
40.00	04000	SUBPROVIDER - IPF	94,233	18,746	855	5,269	40.00
43.00	04300	NURSERY	19,357	1,327	241	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	347,206	80,715	5,364	33,970	50.00
51.00	05100	RECOVERY ROOM	64,845	18,283	2,093	3,185	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,989	3,026	1,618	0	52.00
53.00	05300	ANESTHESIOLOGY	55,965	1,389	0	340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,169	35,199	1,366	3,138	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	103,357	46,235	0	8,899	55.00
56.00	05600	RADIOISOTOPE	100,071	5,647	890	878	56.00
57.00	05700	CT SCAN	37,019	3,282	590	550	57.00
58.00	05800	MRI	33,424	4,393	203	527	58.00
59.00	05900	CARDIAC CATHETERIZATION	50,113	17,008	501	1,932	59.00
60.00	06000	LABORATORY	314,787	28,722	5	4,578	60.00
65.00	06500	RESPIRATORY THERAPY	51,680	3,322	0	749	65.00
66.00	06600	PHYSICAL THERAPY	151,479	30,919	329	4,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,413	907	0	410	67.00
68.00	06800	SPEECH PATHOLOGY	19,768	6,654	7	761	68.00
69.00	06900	ELECTROCARDIOLOGY	60,890	33,825	459	5,375	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77,129	9,873	29	1,593	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112,203	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	233,072	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	439,678	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	24,066	5,847	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	4,929	4,475	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	15,397	11,701	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	24,331	4,178	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	17,844	4,733	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	40,983	13,638	0	0	88.04
91.00	09100	EMERGENCY	228,841	38,369	6,307	13,501	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				3,783	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	150,156	8,580	0	820	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	79,964	3,226	0	234	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,439,080	661,152	33,438	102,341	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,617,478	311,762	3	18,888	192.00
194.00	07950	WELLNESS	28,714	50,106	0	3,981	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	100,504	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	22,519	6,260	0	937	194.03
194.05	07954	MISC. NONREIMBURSABLE	265,873	49,413	0	2,705	194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,474,168	1,078,693	33,441	128,852	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	147,369					11.00
13.00	01300	NURSING ADMINISTRATION	3,253	210,240				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,289	0	476,561			14.00
15.00	01500	PHARMACY	2,530	0	0	149,154		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,097	0	0	0	152,805	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,495	96,943	0	0	5,984	30.00
32.00	03200	CORONARY CARE UNIT	3,012	10,657	0	0	677	32.00
40.00	04000	SUBPROVIDER - IPF	3,856	10,611	0	0	1,278	40.00
43.00	04300	NURSERY	1,084	4,254	0	0	365	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,447	40,073	0	0	14,714	50.00
51.00	05100	RECOVERY ROOM	2,892	9,934	0	0	2,890	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,566	6,161	0	0	1,325	52.00
53.00	05300	ANESTHESIOLOGY	2,048	406	0	0	2,940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,061	0	0	0	8,893	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,133	0	0	0	2,806	55.00
56.00	05600	RADIOISOTOPE	2,048	0	0	0	8,289	56.00
57.00	05700	CT SCAN	1,084	0	0	0	14,952	57.00
58.00	05800	MRI	723	0	0	0	5,243	58.00
59.00	05900	CARDIAC CATHETERIZATION	843	0	0	0	3,850	59.00
60.00	06000	LABORATORY	11,447	0	0	0	11,956	60.00
65.00	06500	RESPIRATORY THERAPY	2,410	0	0	0	2,647	65.00
66.00	06600	PHYSICAL THERAPY	3,735	0	0	0	6,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	843	0	0	0	561	67.00
68.00	06800	SPEECH PATHOLOGY	1,325	0	0	0	632	68.00
69.00	06900	ELECTROCARDIOLOGY	3,253	0	0	0	1,807	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,205	0	0	0	1,247	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	152,500	0	6,696	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	324,061	0	6,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	149,154	24,985	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,807	0	0	0	42	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	18	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	66	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	115	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	110	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	251	88.04
91.00	09100	EMERGENCY	10,604	31,201	0	0	12,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,566	0	0	0	1,094	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	723	0	0	0	1,135	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,379	210,240	476,561	149,154	152,805	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,497	0	0	0	0	192.00
194.00	07950	WELLNESS	1,325	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	1,084	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	1,084	0	0	0	0	194.05
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)	147,369	210,240	476,561	149,154	152,805	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,732,833	0	2,732,833	30.00
32.00	03200	CORONARY CARE UNIT	238,984	0	238,984	32.00
40.00	04000	SUBPROVIDER - IPF	286,098	0	286,098	40.00
43.00	04300	NURSERY	116,134	0	116,134	43.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,697,526	0	2,697,526	50.00
51.00	05100	RECOVERY ROOM	285,374	0	285,374	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	108,085	0	108,085	52.00
53.00	05300	ANESTHESIOLOGY	181,279	0	181,279	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,397,113	0	1,397,113	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,110,641	0	1,110,641	55.00
56.00	05600	RADIOISOTOPE	596,612	0	596,612	56.00
57.00	05700	CT SCAN	186,191	0	186,191	57.00
58.00	05800	MRI	218,945	0	218,945	58.00
59.00	05900	CARDIAC CATHETERIZATION	741,232	0	741,232	59.00
60.00	06000	LABORATORY	953,913	0	953,913	60.00
65.00	06500	RESPIRATORY THERAPY	153,530	0	153,530	65.00
66.00	06600	PHYSICAL THERAPY	426,417	0	426,417	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,871	0	26,871	67.00
68.00	06800	SPEECH PATHOLOGY	92,997	0	92,997	68.00
69.00	06900	ELECTROCARDIOLOGY	438,772	0	438,772	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	177,768	0	177,768	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	271,399	0	271,399	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	564,102	0	564,102	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	613,817	0	613,817	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	68,515	0	68,515	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	40,000	0	40,000	88.00
88.01	08801	RURAL HEALTH CLINIC II	98,828	0	98,828	88.01
88.02	08802	RURAL HEALTH CLINIC III	66,431	0	66,431	88.02
88.03	08803	RURAL HEALTH CLINIC IV	54,051	0	54,051	88.03
88.04	08805	RURAL HEALTH CLINIC V	149,965	0	149,965	88.04
91.00	09100	EMERGENCY	678,491	0	678,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	217,037	0	217,037	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	104,763	0	104,763	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,094,714	0	16,094,714	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,176,137	0	4,176,137	192.00
194.00	07950	WELLNESS	443,601	0	443,601	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	233,515	0	233,515	194.01
194.02	07951	LIFELINE	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	74,999	0	74,999	194.03
194.05	07954	MISC. NONREIMBURSABLE	680,019	0	680,019	194.05
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,702,985	0	21,702,985	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0189

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

Worksheet B-1

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	586,490					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,168,738				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,658	2,840	148,685,556			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	45,503	4,951,197	13,105,939	-42,093,589	242,201,667	5.00
7.00	00700	OPERATION OF PLANT	35,719	398,326	1,314,067	0	6,207,170	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	0	31,613	0	679,596	8.00
9.00	00900	HOUSEKEEPING	2,592	16,344	1,642,596	0	2,616,799	9.00
10.00	01000	DIETARY	6,564	14,237	433,362	0	1,018,071	10.00
11.00	01100	CAFETERIA	3,973	37,235	1,133,386	0	1,554,314	11.00
13.00	01300	NURSING ADMINISTRATION	2,017	84,940	1,810,686	0	2,806,170	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,672	265,372	656,913	0	2,211,449	14.00
15.00	01500	PHARMACY	2,935	28,620	1,735,103	0	2,594,127	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,854	24,000	1,559,193	0	2,378,153	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	66,300	793,996	17,002,752	0	21,318,415	30.00
32.00	03200	CORONARY CARE UNIT	4,908	51,660	1,604,395	0	3,144,767	32.00
40.00	04000	SUBPROVIDER - IPF	8,717	21,460	3,728,853	0	3,525,357	40.00
43.00	04300	NURSERY	617	68,488	499,104	0	724,169	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	37,534	1,425,447	6,066,129	0	12,989,376	50.00
51.00	05100	RECOVERY ROOM	8,502	64,333	1,526,198	0	2,425,925	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	40,152	757,421	0	1,084,501	52.00
53.00	05300	ANESTHESIOLOGY	646	90,802	5,679,190	0	2,093,698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,368	792,051	6,765,575	0	7,301,485	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	21,500	571,451	2,700,325	0	3,866,702	55.00
56.00	05600	RADIOISOTOPE	2,626	373,572	1,525,898	0	3,743,765	56.00
57.00	05700	CT SCAN	1,526	91,995	560,773	0	1,384,917	57.00
58.00	05800	MRI	2,043	125,025	401,233	0	1,250,412	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,909	477,319	620,249	0	1,874,801	59.00
60.00	06000	LABORATORY	13,356	349,499	5,327,492	0	11,776,526	60.00
65.00	06500	RESPIRATORY THERAPY	1,545	61,493	1,204,718	0	1,933,392	65.00
66.00	06600	PHYSICAL THERAPY	14,378	44,086	3,077,907	0	5,667,007	66.00
67.00	06700	OCCUPATIONAL THERAPY	422	348	504,588	0	688,836	67.00
68.00	06800	SPEECH PATHOLOGY	3,094	21,582	787,335	0	739,556	68.00
69.00	06900	ELECTROCARDIOLOGY	15,729	117,579	1,463,434	0	2,277,954	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	25,174	1,571,293	0	2,885,467	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,197,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	8,719,481	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	16,448,861	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	2,766	663,485	0	900,321	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,081	4,280	92,521	0	184,405	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,441	4,233	320,562	0	576,024	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,943	11,602	618,475	0	910,251	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,201	3,624	409,091	0	667,578	88.03
88.04	08805	RURAL HEALTH CLINIC V	6,342	14,448	984,922	0	1,533,211	88.04
91.00	09100	EMERGENCY	17,842	94,110	9,758,978	0	8,561,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	3,990	4,030	3,822,705	0	5,617,504	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	1,500	522	1,618,210	0	2,991,554	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	392,326	11,570,238	105,086,669	-42,093,589	166,070,920	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	144,975	351,654	38,760,740	0	60,507,492	192.00
194.00	07950	WELLNESS	23,300	62,404	456,528	0	1,074,219	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	110,997	1,343,065	0	3,759,960	194.01
194.02	07951	LIFELINE	0	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	7,032	676,014	0	842,464	194.03
194.05	07954	MISC. NONREIMBURSABLE	22,978	66,413	2,362,540	0	9,946,612	194.05
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)	7,168,537	14,534,448	35,483,795		42,093,589	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.222778	1.194409	0.238650		0.173796	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0189

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

Worksheet B-1

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			48,103		6,474,168	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000324		0.026730	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: 14-0189

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

Worksheet B-1

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
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
7.00	00700	OPERATION OF PLANT	501,610				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,115,076			8.00
9.00	00900	HOUSEKEEPING	2,592	53,236	11,004		9.00
10.00	01000	DIETARY	6,564	17,209	0	165,253	10.00
11.00	01100	CAFETERIA	3,973	0	331	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,017	0	81	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,672	22,699	120	0	14.00
15.00	01500	PHARMACY	2,935	0	30	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,854	0	49	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	66,300	303,937	111	133,354	30.00
32.00	03200	CORONARY CARE UNIT	4,908	22,458	226	5,332	32.00
40.00	04000	SUBPROVIDER - IPF	8,717	28,509	450	21,205	40.00
43.00	04300	NURSERY	617	8,043	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,534	178,845	2,901	872	50.00
51.00	05100	RECOVERY ROOM	8,502	69,787	272	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	53,951	0	0	52.00
53.00	05300	ANESTHESIOLOGY	646	0	29	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,368	45,534	268	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	21,500	0	760	0	55.00
56.00	05600	RADIOISOTOPE	2,626	29,682	75	0	56.00
57.00	05700	CT SCAN	1,526	19,672	47	0	57.00
58.00	05800	MRI	2,043	6,782	45	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,909	16,712	165	0	59.00
60.00	06000	LABORATORY	13,356	158	391	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,545	0	64	0	65.00
66.00	06600	PHYSICAL THERAPY	14,378	10,965	387	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	422	0	35	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,094	220	65	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15,729	15,316	459	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	971	136	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,081	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,441	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,943	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,201	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	6,342	0	0	0	88.04
91.00	09100	EMERGENCY	17,842	210,295	1,153	4,490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,990	0	70	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	1,500	0	20	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	307,446	1,114,981	8,740	165,253	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	144,975	95	1,613	0	192.00
194.00	07950	WELLNESS	23,300	0	340	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	0	80	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	22,978	0	231	0	194.05
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)	7,285,951	813,133	3,148,058	1,302,900	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.525131	0.729218	286.083061	7.884274	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,078,693	33,441	128,852	139,220	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.150462	0.029990	11.709560	0.842466	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0189

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

Worksheet B-1

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
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: 14-0189

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

Worksheet B-1

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	931,639				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100			14.00
15.00	01500	PHARMACY	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	799,996,184	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	429,582	0	0	31,328,958	30.00
32.00	03200	CORONARY CARE UNIT	47,225	0	0	3,542,123	32.00
40.00	04000	SUBPROVIDER - IPF	47,021	0	0	6,690,438	40.00
43.00	04300	NURSERY	18,853	0	0	1,911,780	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	177,577	0	0	77,034,399	50.00
51.00	05100	RECOVERY ROOM	44,019	0	0	15,128,395	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,303	0	0	6,935,242	52.00
53.00	05300	ANESTHESIOLOGY	1,798	0	0	15,392,470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	46,558,976	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	14,688,573	55.00
56.00	05600	RADIOISOTOPE	0	0	0	43,400,316	56.00
57.00	05700	CT SCAN	0	0	0	78,283,453	57.00
58.00	05800	MRI	0	0	0	27,452,714	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	20,156,034	59.00
60.00	06000	LABORATORY	0	0	0	62,594,799	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,859,123	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	31,568,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,936,480	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,308,905	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	9,462,910	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,527,836	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32	0	35,060,114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	68	0	36,489,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	130,779,081	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	218,379	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	95,468	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	347,054	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	604,053	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	578,057	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	1,316,246	88.04
91.00	09100	EMERGENCY	138,261	0	0	64,074,926	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	5,729,375	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	5,941,330	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	931,639	100	100	799,996,184	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	WELLNESS	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	194.01
194.02	07951	LIFELINE	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	0	0	0	194.05
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)	3,389,984	2,774,296	3,130,133	2,916,421	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.638731	27,742.960000	31,301.330000	0.003646	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	210,240	476,561	149,154	152,805	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0189

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

Worksheet B-1

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.225667	4,765.610000	1,491.540000	0.000191		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 9:04 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	29,377,581		29,377,581	0	29,377,581	30.00	
32.00	03200	CORONARY CARE UNIT	4,110,839		4,110,839	0	4,110,839	32.00	
40.00	04000	SUBPROVIDER - IPF	4,828,593		4,828,593	0	4,828,593	40.00	
43.00	04300	NURSERY	954,973		954,973	0	954,973	43.00	
45.00	04500	NURSING FACILITY	0		0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	17,839,864		17,839,864	0	17,839,864	50.00	
51.00	05100	RECOVERY ROOM	3,353,863		3,353,863	0	3,353,863	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,478,409		1,478,409	0	1,478,409	52.00	
53.00	05300	ANESTHESIOLOGY	2,565,395		2,565,395	0	2,565,395	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,155,718		9,155,718	0	9,155,718	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	5,164,013		5,164,013	0	5,164,013	55.00	
56.00	05600	RADIOISOTOPE	4,661,377		4,661,377	0	4,661,377	56.00	
57.00	05700	CT SCAN	1,975,535		1,975,535	0	1,975,535	57.00	
58.00	05800	MRI	1,625,015		1,625,015	0	1,625,015	58.00	
59.00	05900	CARDIAC CATHETERIZATION	2,459,708		2,459,708	0	2,459,708	59.00	
60.00	06000	LABORATORY	14,510,988		14,510,988	0	14,510,988	60.00	
65.00	06500	RESPIRATORY THERAPY	2,393,016	0	2,393,016	0	2,393,016	65.00	
66.00	06600	PHYSICAL THERAPY	7,144,670	0	7,144,670	0	7,144,670	66.00	
67.00	06700	OCCUPATIONAL THERAPY	846,717	0	846,717	0	846,717	67.00	
68.00	06800	SPEECH PATHOLOGY	961,628	0	961,628	0	961,628	68.00	
69.00	06900	ELECTROCARDIOLOGY	3,122,945		3,122,945	0	3,122,945	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	3,533,214		3,533,214	0	3,533,214	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,942,770		5,942,770	0	5,942,770	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,254,453		12,254,453	0	12,254,453	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	22,914,198		22,914,198	0	22,914,198	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,121,329		1,121,329	0	1,121,329	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	247,029		247,029	0	247,029	88.00	
88.01	08801	RURAL HEALTH CLINIC II	756,431		756,431	0	756,431	88.01	
88.02	08802	RURAL HEALTH CLINIC III	1,098,873		1,098,873	0	1,098,873	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	817,678		817,678	0	817,678	88.03	
88.04	08805	RURAL HEALTH CLINIC V	1,896,594		1,896,594	0	1,896,594	88.04	
91.00	09100	EMERGENCY	11,705,842		11,705,842	23,975	11,729,817	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,488,102		8,488,102		8,488,102	92.00	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	6,713,687		6,713,687		6,713,687	101.00	
SPECIAL PURPOSE COST CENTERS									
116.00	11600	HOSPICE	3,570,344		3,570,344		3,570,344	116.00	
200.00		Subtotal (see instructions)	199,591,391	0	199,591,391	23,975	199,615,366	200.00	
201.00		Less Observation Beds	8,488,102		8,488,102		8,488,102	201.00	
202.00		Total (see instructions)	191,103,289	0	191,103,289	23,975	191,127,264	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 9:04 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,990,995		22,990,995		30.00
32.00	03200	CORONARY CARE UNIT	3,542,123		3,542,123		32.00
40.00	04000	SUBPROVIDER - IPF	6,690,438		6,690,438		40.00
43.00	04300	NURSERY	1,911,780		1,911,780		43.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,588,425	57,445,974	77,034,399	0.231583	0.000000
51.00	05100	RECOVERY ROOM	4,197,788	10,930,607	15,128,395	0.221693	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,293,522	641,720	6,935,242	0.213173	0.000000
53.00	05300	ANESTHESIOLOGY	5,973,723	9,418,747	15,392,470	0.166666	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,620,992	41,937,984	46,558,976	0.196648	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	54,688	14,633,885	14,688,573	0.351567	0.000000
56.00	05600	RADIOISOTOPE	6,250,949	37,149,367	43,400,316	0.107404	0.000000
57.00	05700	CT SCAN	14,642,722	63,640,731	78,283,453	0.025236	0.000000
58.00	05800	MRI	2,640,706	24,812,008	27,452,714	0.059193	0.000000
59.00	05900	CARDIAC CATHETERIZATION	5,252,044	14,903,990	20,156,034	0.122033	0.000000
60.00	06000	LABORATORY	10,978,948	51,615,851	62,594,799	0.231824	0.000000
65.00	06500	RESPIRATORY THERAPY	11,434,418	2,424,705	13,859,123	0.172667	0.000000
66.00	06600	PHYSICAL THERAPY	2,142,705	29,426,043	31,568,748	0.226321	0.000000
67.00	06700	OCCUPATIONAL THERAPY	691,352	2,245,128	2,936,480	0.288344	0.000000
68.00	06800	SPEECH PATHOLOGY	287,823	3,021,082	3,308,905	0.290618	0.000000
69.00	06900	ELECTROCARDIOLOGY	1,638,457	7,824,453	9,462,910	0.330020	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	326,917	6,200,919	6,527,836	0.541253	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,306,799	22,753,315	35,060,114	0.169502	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,967,727	10,521,702	36,489,429	0.335836	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	27,263,676	103,515,405	130,779,081	0.175213	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	218,379	218,379	5.134784	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	95,468	95,468		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	347,054	347,054		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	604,053	604,053		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	578,057	578,057		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	1,316,246	1,316,246		88.04
91.00	09100	EMERGENCY	12,928,913	51,146,013	64,074,926	0.182690	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,337,963	8,337,963	1.018007	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	5,729,375	5,729,375		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	5,941,330	5,941,330		116.00
200.00		Subtotal (see instructions)	210,618,630	589,377,554	799,996,184		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	210,618,630	589,377,554	799,996,184		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
32.00	03200	CORONARY CARE UNIT				32.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.231583			50.00
51.00	05100	RECOVERY ROOM	0.221693			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.213173			52.00
53.00	05300	ANESTHESIOLOGY	0.166666			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196648			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.351567			55.00
56.00	05600	RADIOISOTOPE	0.107404			56.00
57.00	05700	CT SCAN	0.025236			57.00
58.00	05800	MRI	0.059193			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.122033			59.00
60.00	06000	LABORATORY	0.231824			60.00
65.00	06500	RESPIRATORY THERAPY	0.172667			65.00
66.00	06600	PHYSICAL THERAPY	0.226321			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288344			67.00
68.00	06800	SPEECH PATHOLOGY	0.290618			68.00
69.00	06900	ELECTROCARDIOLOGY	0.330020			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.541253			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.169502			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.335836			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175213			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.134784			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
88.02	08802	RURAL HEALTH CLINIC III				88.02
88.03	08803	RURAL HEALTH CLINIC IV				88.03
88.04	08805	RURAL HEALTH CLINIC V				88.04
91.00	09100	EMERGENCY	0.183064			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.018007			92.00
OTHER REIMBURSABLE COST CENTERS						
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: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 9:04 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,377,581		29,377,581	0	29,377,581	30.00
32.00	03200	CORONARY CARE UNIT	4,110,839		4,110,839	0	4,110,839	32.00
40.00	04000	SUBPROVIDER - IPF	4,828,593		4,828,593	0	4,828,593	40.00
43.00	04300	NURSERY	954,973		954,973	0	954,973	43.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,839,864		17,839,864	0	17,839,864	50.00
51.00	05100	RECOVERY ROOM	3,353,863		3,353,863	0	3,353,863	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,478,409		1,478,409	0	1,478,409	52.00
53.00	05300	ANESTHESIOLOGY	2,565,395		2,565,395	0	2,565,395	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,155,718		9,155,718	0	9,155,718	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,164,013		5,164,013	0	5,164,013	55.00
56.00	05600	RADIOISOTOPE	4,661,377		4,661,377	0	4,661,377	56.00
57.00	05700	CT SCAN	1,975,535		1,975,535	0	1,975,535	57.00
58.00	05800	MRI	1,625,015		1,625,015	0	1,625,015	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,459,708		2,459,708	0	2,459,708	59.00
60.00	06000	LABORATORY	14,510,988		14,510,988	0	14,510,988	60.00
65.00	06500	RESPIRATORY THERAPY	2,393,016	0	2,393,016	0	2,393,016	65.00
66.00	06600	PHYSICAL THERAPY	7,144,670	0	7,144,670	0	7,144,670	66.00
67.00	06700	OCCUPATIONAL THERAPY	846,717	0	846,717	0	846,717	67.00
68.00	06800	SPEECH PATHOLOGY	961,628	0	961,628	0	961,628	68.00
69.00	06900	ELECTROCARDIOLOGY	3,122,945		3,122,945	0	3,122,945	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,533,214		3,533,214	0	3,533,214	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,942,770		5,942,770	0	5,942,770	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,254,453		12,254,453	0	12,254,453	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,914,198		22,914,198	0	22,914,198	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,121,329		1,121,329	0	1,121,329	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	247,029		247,029	0	247,029	88.00
88.01	08801	RURAL HEALTH CLINIC II	756,431		756,431	0	756,431	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,098,873		1,098,873	0	1,098,873	88.02
88.03	08803	RURAL HEALTH CLINIC IV	817,678		817,678	0	817,678	88.03
88.04	08805	RURAL HEALTH CLINIC V	1,896,594		1,896,594	0	1,896,594	88.04
91.00	09100	EMERGENCY	11,705,842		11,705,842	23,975	11,729,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,488,102		8,488,102		8,488,102	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,713,687		6,713,687		6,713,687	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	3,570,344		3,570,344		3,570,344	116.00
200.00		Subtotal (see instructions)	199,591,391	0	199,591,391	23,975	199,615,366	200.00
201.00		Less Observation Beds	8,488,102		8,488,102		8,488,102	201.00
202.00		Total (see instructions)	191,103,289	0	191,103,289	23,975	191,127,264	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 9:04 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,990,995		22,990,995		30.00
32.00	03200	CORONARY CARE UNIT	3,542,123		3,542,123		32.00
40.00	04000	SUBPROVIDER - IPF	6,690,438		6,690,438		40.00
43.00	04300	NURSERY	1,911,780		1,911,780		43.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,588,425	57,445,974	77,034,399	0.231583	0.000000
51.00	05100	RECOVERY ROOM	4,197,788	10,930,607	15,128,395	0.221693	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,293,522	641,720	6,935,242	0.213173	0.000000
53.00	05300	ANESTHESIOLOGY	5,973,723	9,418,747	15,392,470	0.166666	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,620,992	41,937,984	46,558,976	0.196648	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	54,688	14,633,885	14,688,573	0.351567	0.000000
56.00	05600	RADIOISOTOPE	6,250,949	37,149,367	43,400,316	0.107404	0.000000
57.00	05700	CT SCAN	14,642,722	63,640,731	78,283,453	0.025236	0.000000
58.00	05800	MRI	2,640,706	24,812,008	27,452,714	0.059193	0.000000
59.00	05900	CARDIAC CATHETERIZATION	5,252,044	14,903,990	20,156,034	0.122033	0.000000
60.00	06000	LABORATORY	10,978,948	51,615,851	62,594,799	0.231824	0.000000
65.00	06500	RESPIRATORY THERAPY	11,434,418	2,424,705	13,859,123	0.172667	0.000000
66.00	06600	PHYSICAL THERAPY	2,142,705	29,426,043	31,568,748	0.226321	0.000000
67.00	06700	OCCUPATIONAL THERAPY	691,352	2,245,128	2,936,480	0.288344	0.000000
68.00	06800	SPEECH PATHOLOGY	287,823	3,021,082	3,308,905	0.290618	0.000000
69.00	06900	ELECTROCARDIOLOGY	1,638,457	7,824,453	9,462,910	0.330020	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	326,917	6,200,919	6,527,836	0.541253	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,306,799	22,753,315	35,060,114	0.169502	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,967,727	10,521,702	36,489,429	0.335836	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	27,263,676	103,515,405	130,779,081	0.175213	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	218,379	218,379	5.134784	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	95,468	95,468	2.587558	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	347,054	347,054	2.179577	0.000000
88.02	08802	RURAL HEALTH CLINIC III	0	604,053	604,053	1.819167	0.000000
88.03	08803	RURAL HEALTH CLINIC IV	0	578,057	578,057	1.414528	0.000000
88.04	08805	RURAL HEALTH CLINIC V	0	1,316,246	1,316,246	1.440912	0.000000
91.00	09100	EMERGENCY	12,928,913	51,146,013	64,074,926	0.182690	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	8,337,963	8,337,963	1.018007	0.000000
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	5,729,375	5,729,375		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	5,941,330	5,941,330		116.00
200.00		Subtotal (see instructions)	210,618,630	589,377,554	799,996,184		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	210,618,630	589,377,554	799,996,184		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
32.00	03200	CORONARY CARE UNIT				32.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
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
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000			88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000			88.04
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part I Date/Time Prepared: 11/25/2019 9:04 am		
				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	2,732,833	0	2,732,833	22,694	120.42	30.00	
32.00	CORONARY CARE UNIT	238,984		238,984	1,704	140.25	32.00	
40.00	SUBPROVIDER - IPF	286,098	0	286,098	4,939	57.93	40.00	
43.00	NURSERY	116,134		116,134	1,240	93.66	43.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (lines 30 through 199)	3,374,049		3,374,049	30,577		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	8,838	1,064,272					30.00
32.00	CORONARY CARE UNIT	947	132,817					32.00
40.00	SUBPROVIDER - IPF	1,566	90,718					40.00
43.00	NURSERY	0	0					43.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	11,351	1,287,807					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description			Title XVIII		Hospital	PPS		
			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	2,697,526	77,034,399	0.035017	10,419,592	364,863	50.00
51.00	05100	RECOVERY ROOM	285,374	15,128,395	0.018863	2,043,430	38,545	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	108,085	6,935,242	0.015585	3,393	53	52.00
53.00	05300	ANESTHESIOLOGY	181,279	15,392,470	0.011777	2,846,136	33,519	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,397,113	46,558,976	0.030007	2,566,329	77,008	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,110,641	14,688,573	0.075613	20,566	1,555	55.00
56.00	05600	RADIOISOTOPE	596,612	43,400,316	0.013747	3,083,377	42,387	56.00
57.00	05700	CT SCAN	186,191	78,283,453	0.002378	8,038,741	19,116	57.00
58.00	05800	MRI	218,945	27,452,714	0.007975	1,270,819	10,135	58.00
59.00	05900	CARDIAC CATHETERIZATION	741,232	20,156,034	0.036775	2,250,392	82,758	59.00
60.00	06000	LABORATORY	953,913	62,594,799	0.015239	6,031,258	91,910	60.00
65.00	06500	RESPIRATORY THERAPY	153,530	13,859,123	0.011078	6,387,411	70,760	65.00
66.00	06600	PHYSICAL THERAPY	426,417	31,568,748	0.013508	1,292,853	17,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,871	2,936,480	0.009151	452,436	4,140	67.00
68.00	06800	SPEECH PATHOLOGY	92,997	3,308,905	0.028105	146,479	4,117	68.00
69.00	06900	ELECTROCARDIOLOGY	438,772	9,462,910	0.046368	943,258	43,737	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	177,768	6,527,836	0.027232	174,858	4,762	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	271,399	35,060,114	0.007741	6,198,011	47,979	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	564,102	36,489,429	0.015459	12,549,875	194,009	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	613,817	130,779,081	0.004694	14,221,721	66,757	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	68,515	218,379	0.313744	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	40,000	95,468	0.418989	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	98,828	347,054	0.284763	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	66,431	604,053	0.109975	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	54,051	578,057	0.093505	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	149,965	1,316,246	0.113934	0	0	88.04
91.00	09100	EMERGENCY	678,491	64,074,926	0.010589	8,135,977	86,152	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	789,597	8,337,963	0.094699	0	0	92.00
200.00		Total (lines 50 through 199)	13,188,462	753,190,143		89,076,912	1,301,726	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0189		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/25/2019 9:04 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	0	32.00	
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	
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00	
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	22,694	0.00	8,838		30.00	
32.00	03200	CORONARY CARE UNIT	0	0	1,704	0.00	947		32.00	
40.00	04000	SUBPROVIDER - IPF	0	0	4,939	0.00	1,566		40.00	
43.00	04300	NURSERY	0	0	1,240	0.00	0		43.00	
45.00	04500	NURSING FACILITY	0	0	0	0.00	0		45.00	
200.00	Total (lines 30 through 199)		0	0	30,577		11,351		200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
32.00	03200	CORONARY CARE UNIT	0	0						32.00
40.00	04000	SUBPROVIDER - IPF	0	0						40.00
43.00	04300	NURSERY	0	0						43.00
45.00	04500	NURSING FACILITY	0	0						45.00
200.00	Total (lines 30 through 199)		0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0189		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 9:04 am	
			Title XVIII		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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
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
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0189		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 9:04 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	77,034,399	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	15,128,395	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	6,935,242	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	15,392,470	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	46,558,976	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	14,688,573	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	43,400,316	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	78,283,453	0.000000	57.00
58.00	05800	MRI	0	0	0	0	27,452,714	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	20,156,034	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	62,594,799	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	13,859,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	31,568,748	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,936,480	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3,308,905	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	9,462,910	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	6,527,836	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	35,060,114	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	36,489,429	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	130,779,081	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	218,379	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	95,468	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	347,054	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	604,053	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	578,057	0.000000	88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0	0	0	1,316,246	0.000000	88.04
91.00	09100	EMERGENCY	0	0	0	0	64,074,926	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	8,337,963	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	753,190,143		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/25/2019 9:04 am

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	10,419,592	0	23,421,812	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,043,430	0	2,535,951	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,393	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,846,136	0	3,786,132	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,566,329	0	11,740,356	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	20,566	0	5,382,738	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	3,083,377	0	9,467,307	0	56.00
57.00	05700	CT SCAN	0.000000	8,038,741	0	19,962,343	0	57.00
58.00	05800	MRI	0.000000	1,270,819	0	7,883,529	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,250,392	0	7,238,771	0	59.00
60.00	06000	LABORATORY	0.000000	6,031,258	0	5,231,760	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,387,411	0	868,355	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,292,853	0	484,505	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	452,436	0	45,157	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	146,479	0	335,563	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	943,258	0	2,618,291	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	174,858	0	558,129	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,198,011	0	5,355,811	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,549,875	0	3,948,026	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	14,221,721	0	48,352,585	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
	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
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	88.04
91.00	09100	EMERGENCY	0.000000	8,135,977	0	14,790,448	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	3,783,202	0	92.00
200.00		Total (lines 50 through 199)		89,076,912	0	177,790,771	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0189		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 11/25/2019 9:04 am
				Title XVIII		Hospital	PPS
Cost Center Description				PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
				21.00	24.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0			50.00
51.00	05100	RECOVERY ROOM	0	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300	ANESTHESIOLOGY	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0			55.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000	LABORATORY	0	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0			70.00
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0			75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0			76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0			88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0			88.04
91.00	09100	EMERGENCY	0	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
200.00		Total (lines 50 through 199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/25/2019 9:04 am

			Title XVIII		Hospital		PPS	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.231583	23,421,812	0	0	5,424,093	50.00
51.00	05100	RECOVERY ROOM	0.221693	2,535,951	0	0	562,203	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.213173	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.166666	3,786,132	0	0	631,019	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196648	11,740,356	0	0	2,308,718	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.351567	5,382,738	0	0	1,892,393	55.00
56.00	05600	RADIOISOTOPE	0.107404	9,467,307	0	0	1,016,827	56.00
57.00	05700	CT SCAN	0.025236	19,962,343	0	0	503,770	57.00
58.00	05800	MRI	0.059193	7,883,529	0	0	466,650	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.122033	7,238,771	0	0	883,369	59.00
60.00	06000	LABORATORY	0.231824	5,231,760	0	0	1,212,848	60.00
65.00	06500	RESPIRATORY THERAPY	0.172667	868,355	0	0	149,936	65.00
66.00	06600	PHYSICAL THERAPY	0.226321	484,505	0	0	109,654	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288344	45,157	0	0	13,021	67.00
68.00	06800	SPEECH PATHOLOGY	0.290618	335,563	0	0	97,521	68.00
69.00	06900	ELECTROCARDIOLOGY	0.330020	2,618,291	0	0	864,088	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.541253	558,129	0	0	302,089	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.169502	5,355,811	0	0	907,821	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.335836	3,948,026	0	0	1,325,889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175213	48,352,585	0	129,624	8,472,001	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.134784	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000				0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000				0	88.04
91.00	09100	EMERGENCY	0.182690	14,790,448	0	0	2,702,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.018007	3,783,202	0	0	3,851,326	92.00
200.00		Subtotal (see instructions)		177,790,771	0	129,624	33,697,303	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		177,790,771	0	129,624	33,697,303	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/25/2019 9:04 am

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
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	22,712		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
88.04	08805	RURAL HEALTH CLINIC V	0	0		88.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	22,712		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	22,712		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared: 11/25/2019 9:04 am	
				Component CCN: 14-S189			
				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	2,697,526	77,034,399	0.035017	0	0
51.00	05100	RECOVERY ROOM	285,374	15,128,395	0.018863	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	108,085	6,935,242	0.015585	0	0
53.00	05300	ANESTHESIOLOGY	181,279	15,392,470	0.011777	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,397,113	46,558,976	0.030007	42,586	1,278
55.00	05500	RADIOLOGY-THERAPEUTIC	1,110,641	14,688,573	0.075613	0	0
56.00	05600	RADIOISOTOPE	596,612	43,400,316	0.013747	31,181	429
57.00	05700	CT SCAN	186,191	78,283,453	0.002378	109,794	261
58.00	05800	MRI	218,945	27,452,714	0.007975	65,516	522
59.00	05900	CARDIAC CATHETERIZATION	741,232	20,156,034	0.036775	0	0
60.00	06000	LABORATORY	953,913	62,594,799	0.015239	297,539	4,534
65.00	06500	RESPIRATORY THERAPY	153,530	13,859,123	0.011078	179,173	1,985
66.00	06600	PHYSICAL THERAPY	426,417	31,568,748	0.013508	8,352	113
67.00	06700	OCCUPATIONAL THERAPY	26,871	2,936,480	0.009151	518	5
68.00	06800	SPEECH PATHOLOGY	92,997	3,308,905	0.028105	956	27
69.00	06900	ELECTROCARDIOLOGY	438,772	9,462,910	0.046368	31,584	1,464
70.00	07000	ELECTROENCEPHALOGRAPHY	177,768	6,527,836	0.027232	7,857	214
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	271,399	35,060,114	0.007741	21,672	168
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	564,102	36,489,429	0.015459	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	613,817	130,779,081	0.004694	255,188	1,198
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	68,515	218,379	0.313744	0	0
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	40,000	95,468	0.418989	0	0
88.01	08801	RURAL HEALTH CLINIC II	98,828	347,054	0.284763	0	0
88.02	08802	RURAL HEALTH CLINIC III	66,431	604,053	0.109975	0	0
88.03	08803	RURAL HEALTH CLINIC IV	54,051	578,057	0.093505	0	0
88.04	08805	RURAL HEALTH CLINIC V	149,965	1,316,246	0.113934	0	0
91.00	09100	EMERGENCY	678,491	64,074,926	0.010589	438,980	4,648
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,337,963	0.000000	0	0
200.00		Total (lines 50 through 199)	12,398,865	753,190,143		1,490,896	16,846

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0189 Component CCN: 14-S189		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 9:04 am	
				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	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
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
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.00
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
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V		0	0	0	0	0	88.04
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0189 Component CCN: 14-S189		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 9:04 am	
				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)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	77,034,399	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	15,128,395	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	6,935,242	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	15,392,470	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	46,558,976	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	14,688,573	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	43,400,316	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	78,283,453	0.000000	57.00
58.00	05800	MRI		0	0	0	27,452,714	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	20,156,034	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	62,594,799	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	13,859,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	31,568,748	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,936,480	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	3,308,905	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	9,462,910	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	6,527,836	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	35,060,114	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	36,489,429	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	130,779,081	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	218,379	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	95,468	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	347,054	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III		0	0	0	604,053	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV		0	0	0	578,057	0.000000	88.03
88.04	08805	RURAL HEALTH CLINIC V		0	0	0	1,316,246	0.000000	88.04
91.00	09100	EMERGENCY		0	0	0	64,074,926	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	8,337,963	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	753,190,143		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0189 Component CCN: 14-S189		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/25/2019 9:04 am	
				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
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	42,586	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	31,181	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	109,794	0	0	0	0	57.00
58.00	05800	MRI	0.000000	65,516	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	297,539	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	179,173	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	8,352	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	518	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	956	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	31,584	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	7,857	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	21,672	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	255,188	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	0	88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000	0	0	0	0	0	88.04
91.00	09100	EMERGENCY	0.000000	438,980	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,490,896	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0189 Component CCN: 14-S189		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 11/25/2019 9:04 am
			Title XVIII		Subprovider - IPF	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
51.00	05100	RECOVERY ROOM	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00	
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	
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00	
60.00	06000	LABORATORY	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00	
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	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	0	0	88.03	
88.04	08805	RURAL HEALTH CLINIC V	0	0	88.04	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
200.00		Total (lines 50 through 199)	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 9:04 am	
		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)			22,694	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			22,694	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)			16,137	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)			8,838	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)			29,377,581	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)			29,377,581	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)			29,377,581	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)			1,294.51	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			11,440,879	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)			11,440,879	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0189

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

Worksheet D-1

Date/Time Prepared:
11/25/2019 9:04 am

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
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					
44.00	CORONARY CARE UNIT	4,110,839	1,704	2,412.46	947	2,284,600
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					17,356,019
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					31,081,498
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,197,089
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,301,726
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,498,815
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					28,582,683
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					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)					6,557
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,294.51
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,488,102

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0189

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

Worksheet D-1

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,732,833	29,377,581	0.093024	8,488,102	789,597
91.00	Nursing School cost	0	29,377,581	0.000000	8,488,102	0
92.00	Allied health cost	0	29,377,581	0.000000	8,488,102	0
93.00	All other Medical Education	0	29,377,581	0.000000	8,488,102	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0189 Component CCN: 14-S189	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 9:04 am
		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)		4,939	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,939	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)		4,939	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)		1,566	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)		4,828,593	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)		4,828,593	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)		4,828,593	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)		977.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,531,000	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,531,000	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1
			Component CCN: 14-S189		Date/Time Prepared: 11/25/2019 9:04 am
			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
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					264,025
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,795,025
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					90,718
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					16,846
52.00 Total Program excludable cost (sum of lines 50 and 51)					107,564
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,687,461
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					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
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0189 Component CCN: 14-S189		Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/25/2019 9:04 am	
		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	286,098	4,828,593	0.059251	0	0 90.00
91.00	Nursing School cost	0	4,828,593	0.000000	0	0 91.00
92.00	Allied health cost	0	4,828,593	0.000000	0	0 92.00
93.00	All other Medical Education	0	4,828,593	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 9:04 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		11,244,243	30.00
32.00	03200	CORONARY CARE UNIT		1,936,061	32.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.231583	10,419,592	50.00
51.00	05100	RECOVERY ROOM	0.221693	2,043,430	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.213173	3,393	52.00
53.00	05300	ANESTHESIOLOGY	0.166666	2,846,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196648	2,566,329	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.351567	20,566	55.00
56.00	05600	RADIOISOTOPE	0.107404	3,083,377	56.00
57.00	05700	CT SCAN	0.025236	8,038,741	57.00
58.00	05800	MRI	0.059193	1,270,819	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.122033	2,250,392	59.00
60.00	06000	LABORATORY	0.231824	6,031,258	60.00
65.00	06500	RESPIRATORY THERAPY	0.172667	6,387,411	65.00
66.00	06600	PHYSICAL THERAPY	0.226321	1,292,853	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.288344	452,436	67.00
68.00	06800	SPEECH PATHOLOGY	0.290618	146,479	68.00
69.00	06900	ELECTROCARDIOLOGY	0.330020	943,258	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.541253	174,858	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.169502	6,198,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.335836	12,549,875	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175213	14,221,721	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.134784	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		88.03
88.04	08805	RURAL HEALTH CLINIC V	0.000000		88.04
91.00	09100	EMERGENCY	0.183064	8,135,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.018007	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		89,076,912	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)		89,076,912	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0189 Component CCN: 14-S189	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/25/2019 9:04 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
32.00	03200 CORONARY CARE UNIT		0		32.00
40.00	04000 SUBPROVIDER - IPF		2,077,076		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.231583	0	0	50.00
51.00	05100 RECOVERY ROOM	0.221693	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.213173	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.166666	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196648	42,586	8,374	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.351567	0	0	55.00
56.00	05600 RADIOISOTOPE	0.107404	31,181	3,349	56.00
57.00	05700 CT SCAN	0.025236	109,794	2,771	57.00
58.00	05800 MRI	0.059193	65,516	3,878	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.122033	0	0	59.00
60.00	06000 LABORATORY	0.231824	297,539	68,977	60.00
65.00	06500 RESPIRATORY THERAPY	0.172667	179,173	30,937	65.00
66.00	06600 PHYSICAL THERAPY	0.226321	8,352	1,890	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.288344	518	149	67.00
68.00	06800 SPEECH PATHOLOGY	0.290618	956	278	68.00
69.00	06900 ELECTROCARDIOLOGY	0.330020	31,584	10,423	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.541253	7,857	4,253	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.169502	21,672	3,673	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.335836	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175213	255,188	44,712	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.134784	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	0.000000		0	88.03
88.04	08805 RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100 EMERGENCY	0.183064	438,980	80,361	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.018007	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,490,896	264,025	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,490,896		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 9:04 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,959,193	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		16,408,720	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)		317,535	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		64.04	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)		4.17	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.54	31.00
32.00	Sum of lines 30 and 31		24.71	32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.60	33.00
34.00	Disproportionate share adjustment (see instructions)		512,830	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/25/2019 9:04 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)	0.000106832	0.000185757	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	722,897	1,536,744	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	182,210	1,149,400	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,331,610		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	23,529,888		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	26,001,645		48.00
		Amount		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		26,001,645	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,743,966	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		11,240	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)		27,756,851	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		27,756,851	61.00
62.00	Deductibles billed to program beneficiaries		2,830,540	62.00
63.00	Coinsurance billed to program beneficiaries		23,935	63.00
64.00	Allowable bad debts (see instructions)		590,861	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		384,060	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		590,861	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		25,286,436	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)		257,971	70.93
70.94	HRR adjustment amount (see instructions)		-140,474	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A
Date/Time Prepared:
11/25/2019 9:04 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	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)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			273,109	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			25,130,824	71.00
71.01	Sequestration adjustment (see instructions)			502,616	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			24,785,375	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			-157,167	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			133,554	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	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

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0189

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

Worksheet DSH

Date/Time Prepared:
11/25/2019 9:04 am

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	4.17	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	20.54	0.00			20.54	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	24.71	0.00			20.54	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	SCH				SCH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	64.04	0.00			64.04	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	9.60	0.00			6.16	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	798	0			798	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	884	0			884	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,162	0			2,162	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	154	0			154	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,998	0			3,998	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	19,081	0			19,081	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	381	0			381	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	19,462	0			19,462	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	20.54	0.00			20.54	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 14-0189		Period: From 07/01/2018 To 06/30/2019		Worksheet DSH Date/Time Prepared: 11/25/2019 9:04 am	
			Title XVIII		Hospital		PPS	
			Original .mcrx Values		Adjusted .mcax Values		Revised	
			Condition	Percentage	Condition	Percentage	Condition	
			1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE								
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	9.60		0.00	True	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00	
30.00	Line 28 or 29 as applicable		9.60		0.00		30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		9.60		0.00		31.00	
			Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
			1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE								
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00	
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00	
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00	
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00	
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00	

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0189

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

Worksheet DSH

Date/Time Prepared:
11/25/2019 9:04 am

Title XVIII

Hospital

PPS

		Revised	
		Percentage	
		6.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE		
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	6.16	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	6.16	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	6.16	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 9:04 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		22,712	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		33,697,303	2.00
3.00	OPPS payments		29,271,779	3.00
4.00	Outlier payment (see instructions)		154,291	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		22,712	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		129,624	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)		129,624	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)		129,624	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		106,912	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)		22,712	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)		29,426,070	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)		5,569,648	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)		23,879,134	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)		23,879,134	30.00
31.00	Primary payer payments		369	31.00
32.00	Subtotal (line 30 minus line 31)		23,878,765	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)		830,346	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		539,725	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		830,346	36.00
37.00	Subtotal (see instructions)		24,418,490	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)			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)		24,418,490	40.00
40.01	Sequestration adjustment (see instructions)		488,370	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		24,032,953	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-102,833	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/25/2019 9:04 am	
		Title XVIII	Hospital	PPS	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)				0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/25/2019 9:04 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		24,818,687		23,918,047	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	01/28/2019	114,906	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	01/28/2019	33,312		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)		-33,312		114,906	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)		24,785,375		24,032,953	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		157,167		102,833	6.02	
7.00	Total Medicare program liability (see instructions)		24,628,208		23,930,120	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: 14-0189 Component CCN: 14-S189		Period: From 07/01/2018 To 06/30/2019		Worksheet E-1 Part I Date/Time Prepared: 11/25/2019 9:04 am	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,233,375		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)		1,233,375		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		70,480		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,303,855		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: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/25/2019 9:04 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0189 Component CCN: 14-S189	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part II Date/Time Prepared: 11/25/2019 9:04 am
		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)			1,473,869 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)			13.531507 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			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)			1,473,869 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)			1,473,869 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,473,869 18.00
19.00	Deductibles			191,936 19.00
20.00	Subtotal (line 18 minus line 19)			1,281,933 20.00
21.00	Coinsurance			23,319 21.00
22.00	Subtotal (line 20 minus line 21)			1,258,614 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			110,539 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			71,850 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			110,539 25.00
26.00	Subtotal (sum of lines 22 and 24)			1,330,464 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			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)			1,330,464 31.00
31.01	Sequestration adjustment (see instructions)			26,609 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			1,233,375 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)			70,480 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

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

Provider CCN: 14-0189

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

Worksheet G

Date/Time Prepared:

11/25/2019 9:04 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	44,275,468	0	0	0	1.00
2.00	Temporary investments	27,014,650	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	124,090,450	0	0	0	4.00
5.00	Other receivable	-68,336,875	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	6,881,426	0	0	0	7.00
8.00	Prepaid expenses	6,524,216	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	140,449,335	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,811,646	0	0	0	12.00
13.00	Land improvements	15,151,436	0	0	0	13.00
14.00	Accumulated depreciation	-6,292,447	0	0	0	14.00
15.00	Buildings	207,367,476	0	0	0	15.00
16.00	Accumulated depreciation	-63,841,160	0	0	0	16.00
17.00	Leasehold improvements	286,453	0	0	0	17.00
18.00	Accumulated depreciation	-243,457	0	0	0	18.00
19.00	Fixed equipment	20,906,074	0	0	0	19.00
20.00	Accumulated depreciation	-13,526,599	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	131,635,810	0	0	0	23.00
24.00	Accumulated depreciation	-84,914,396	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)	210,340,836	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	186,694,295	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	103,722,126	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	290,416,421	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	641,206,592	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	10,160,100	0	0	0	37.00
38.00	Salaries, wages, and fees payable	20,844,144	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,843,834	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	17,074,076	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	55,922,154	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	137,000,187	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	137,000,187	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	192,922,341	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	448,284,251				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)	448,284,251	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	641,206,592	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0189

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

Worksheet G-1

Date/Time Prepared:
11/25/2019 9:04 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		415,022,128		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		33,262,123				2.00
3.00	Total (sum of line 1 and line 2)		448,284,251		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)		448,284,251		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)		448,284,251		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: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	22,990,995		22,990,995	1.00
2.00	SUBPROVIDER - IPF	6,690,438		6,690,438	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	29,681,433		29,681,433	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT	3,542,123		3,542,123	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)	3,542,123		3,542,123	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,223,556		33,223,556	17.00
18.00	Ancillary services	175,425,846	523,678,080	699,103,926	18.00
19.00	Outpatient services	0	51,146,013	51,146,013	19.00
20.00	RURAL HEALTH CLINIC	0	95,468	95,468	20.00
20.01	RURAL HEALTH CLINIC II	0	347,054	347,054	20.01
20.02	RURAL HEALTH CLINIC III	0	604,053	604,053	20.02
20.03	RURAL HEALTH CLINIC IV	0	578,057	578,057	20.03
20.04	RURAL HEALTH CLINIC V	0	1,316,246	1,316,246	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,729,375	5,729,375	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	5,941,330	5,941,330	26.00
27.00	OTHER: NURS IP, HMKRS, ACCRL, OCC HL	2,069,213	627,337	2,696,550	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	210,718,615	590,063,013	800,781,628	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		326,031,857		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)		326,031,857		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0189

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

Worksheet G-3

Date/Time Prepared:
11/25/2019 9:04 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	800,781,628	1.00
2.00	Less contractual allowances and discounts on patients' accounts	527,583,185	2.00
3.00	Net patient revenues (line 1 minus line 2)	273,198,443	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	326,031,857	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-52,833,414	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,041,955	6.00
7.00	Income from investments	11,380,033	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	316,996	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	901,574	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	54,395	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	19,478	21.00
22.00	Rental of hospital space	113,581	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER: PHYSN REV, GRANTS, MISC, OTR	71,267,525	24.00
25.00	Total other income (sum of lines 6-24)	86,095,537	25.00
26.00	Total (line 5 plus line 25)	33,262,123	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)	33,262,123	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0189

Period:

Worksheet H

HHA CCN: 14-7594

From 07/01/2018

Date/Time Prepared:

To 06/30/2019

11/25/2019 9:04 am

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	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	1,039,406	282,893	79,880	125,118	341,037	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,807,994	0	0	0	1,807,994	6.00
7.00	Physical Therapy	572,855	0	0	0	572,855	7.00
8.00	Occupational Therapy	239,292	0	0	0	239,292	8.00
9.00	Speech Pathology	21,691	0	0	0	21,691	9.00
10.00	Medical Social Services	76,395	0	0	0	76,395	10.00
11.00	Home Health Aide	65,072	0	0	0	65,072	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,822,705	282,893	79,880	125,118	341,037	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	1,868,334	0	1,868,334		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,807,994	0	1,807,994		6.00
7.00	Physical Therapy	0	572,855	0	572,855		7.00
8.00	Occupational Therapy	0	239,292	0	239,292		8.00
9.00	Speech Pathology	0	21,691	0	21,691		9.00
10.00	Medical Social Services	0	76,395	0	76,395		10.00
11.00	Home Health Aide	0	65,072	0	65,072		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	4,651,633	0	4,651,633		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: 14-0189

Period:

Worksheet H-1

HHA CCN: 14-7594

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:

11/25/2019 9:04 am

Home Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	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	1,868,334	0	0	0	0	1,868,334	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,807,994	0	0	0	0	1,807,994	6.00
7.00	Physical Therapy	572,855	0	0	0	0	572,855	7.00
8.00	Occupational Therapy	239,292	0	0	0	0	239,292	8.00
9.00	Speech Pathology	21,691	0	0	0	0	21,691	9.00
10.00	Medical Social Services	76,395	0	0	0	0	76,395	10.00
11.00	Home Health Aide	65,072	0	0	0	0	65,072	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)	4,651,633	0	0	0	0	4,651,633	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	1,868,334						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,213,645	3,021,639					6.00
7.00	Physical Therapy	384,538	957,393					7.00
8.00	Occupational Therapy	160,629	399,921					8.00
9.00	Speech Pathology	14,560	36,251					9.00
10.00	Medical Social Services	51,281	127,676					10.00
11.00	Home Health Aide	43,681	108,753					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)		4,651,633					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0189

Period:

Worksheet H-1

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/25/2019 9:04 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & 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	-1,868,334	2,783,299
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	1,807,994	6.00
7.00	Physical Therapy	0	0	0	0	572,855	7.00
8.00	Occupational Therapy	0	0	0	0	239,292	8.00
9.00	Speech Pathology	0	0	0	0	21,691	9.00
10.00	Medical Social Services	0	0	0	0	76,395	10.00
11.00	Home Health Aide	0	0	0	0	65,072	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,868,334	2,783,299
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,868,334
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.671266

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0189

Period:

Worksheet H-2

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 9:04 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	48,769	4,813	912,289	965,871	167,865	1.00
2.00	Skilled Nursing Care	3,021,639	0	0	0	3,021,639	525,148	2.00
3.00	Physical Therapy	957,393	0	0	0	957,393	166,391	3.00
4.00	Occupational Therapy	399,921	0	0	0	399,921	69,505	4.00
5.00	Speech Pathology	36,251	0	0	0	36,251	6,300	5.00
6.00	Medical Social Services	127,676	0	0	0	127,676	22,190	6.00
7.00	Home Health Aide	108,753	0	0	0	108,753	18,901	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)	4,651,633	48,769	4,813	912,289	5,617,504	976,300	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		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	57,955	0	20,026	0	21,013	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)	57,955	0	20,026	0	21,013	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0189

Period:

Worksheet H-2

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 9:04 amHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	20,889	1,253,619	0	1,253,619	1.00
2.00	Skilled Nursing Care	0	0	0	3,546,787	0	3,546,787	2.00
3.00	Physical Therapy	0	0	0	1,123,784	0	1,123,784	3.00
4.00	Occupational Therapy	0	0	0	469,426	0	469,426	4.00
5.00	Speech Pathology	0	0	0	42,551	0	42,551	5.00
6.00	Medical Social Services	0	0	0	149,866	0	149,866	6.00
7.00	Home Health Aide	0	0	0	127,654	0	127,654	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	20,889	6,713,687	0	6,713,687	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		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	814,333	4,361,120					2.00
3.00	Physical Therapy	258,019	1,381,803					3.00
4.00	Occupational Therapy	107,779	577,205					4.00
5.00	Speech Pathology	9,770	52,321					5.00
6.00	Medical Social Services	34,409	184,275					6.00
7.00	Home Health Aide	29,309	156,963					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	1,253,619	6,713,687					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.	0.229598						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: 14-0189

Period:

Worksheet H-2

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/25/2019 9:04 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	Agency 1	OPERATION OF PLANT (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	3,990	4,030	3,822,705	0	965,871	3,990	1.00
2.00	Skilled Nursing Care	0	0	0	0	3,021,639	0	2.00
3.00	Physical Therapy	0	0	0	0	957,393	0	3.00
4.00	Occupational Therapy	0	0	0	0	399,921	0	4.00
5.00	Speech Pathology	0	0	0	0	36,251	0	5.00
6.00	Medical Social Services	0	0	0	0	127,676	0	6.00
7.00	Home Health Aide	0	0	0	0	108,753	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)	3,990	4,030	3,822,705		5,617,504	3,990	20.00
21.00	Total cost to be allocated	48,769	4,813	912,289		976,300	57,955	21.00
22.00	Unit cost multiplier	12.222807	1.194293	0.238650		0.173796	14.525063	22.00
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	70	0	13	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	70	0	13	0	0	20.00
21.00	Total cost to be allocated	0	20,026	0	21,013	0	0	21.00
22.00	Unit cost multiplier	0.000000	286.085714	0.000000	1,616.384615	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0189

Period:

Worksheet H-2

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/25/2019 9:04 amHome Health
Agency I

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Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		15.00	16.00		
1.00	Administrative and General	0	5,729,375		1.00
2.00	Skilled Nursing Care	0	0		2.00
3.00	Physical Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	0	0		7.00
8.00	Supplies (see instructions)	0	0		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19)	0	5,729,375		20.00
21.00	Total cost to be allocated	0	20,889		21.00
22.00	Unit cost multiplier	0.000000	0.003646		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0189

Period:

Worksheet H-3

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 9:04 am

				Title XVIII		Home Health Agency I	PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	4,361,120		4,361,120	17,288	252.26	1.00
2.00	Physical Therapy	3.00	1,381,803	0	1,381,803	6,587	209.78	2.00
3.00	Occupational Therapy	4.00	577,205	0	577,205	2,705	213.38	3.00
4.00	Speech Pathology	5.00	52,321	0	52,321	381	137.33	4.00
5.00	Medical Social Services	6.00	184,275		184,275	216	853.13	5.00
6.00	Home Health Aide	7.00	156,963		156,963	2,160	72.67	6.00
7.00	Total (sum of lines 1-6)		6,713,687	0	6,713,687	29,337		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	11,301			8.00
8.01	Skilled Nursing Care		16580	0	0			8.01
9.00	Physical Therapy		99914	0	4,386			9.00
9.01	Physical Therapy		16580	0	0			9.01
10.00	Occupational Therapy		99914	0	1,793			10.00
10.01	Occupational Therapy		16580	0	0			10.01
11.00	Speech Pathology		99914	0	172			11.00
11.01	Speech Pathology		16580	0	0			11.01
12.00	Medical Social Services		99914	0	189			12.00
12.01	Medical Social Services		16580	0	0			12.01
13.00	Home Health Aide		99914	0	1,897			13.00
13.01	Home Health Aide		16580	0	0			13.01
14.00	Total (sum of lines 8-13)			0	19,738			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 B						
		Part A	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
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	11,301		0	2,850,790		1.00
2.00	Physical Therapy	0	4,386		0	920,095		2.00
3.00	Occupational Therapy	0	1,793		0	382,590		3.00
4.00	Speech Pathology	0	172		0	23,621		4.00
5.00	Medical Social Services	0	189		0	161,242		5.00
6.00	Home Health Aide	0	1,897		0	137,855		6.00
7.00	Total (sum of lines 1-6)	0	19,738		0	4,476,193		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0189

Period:

Worksheet H-3

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 9:04 am

Title XVIII

Home Health
Agency I

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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	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	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	2,850,790						1.00	
2.00	Physical Therapy	920,095						2.00	
3.00	Occupational Therapy	382,590						3.00	
4.00	Speech Pathology	23,621						4.00	
5.00	Medical Social Services	161,242						5.00	
6.00	Home Health Aide	137,855						6.00	
7.00	Total (sum of lines 1-6)	4,476,193						7.00	
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0189

Period:

Worksheet H-3

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/25/2019 9:04 am

Title XVIII

Home Health
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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	0.226321	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.288344	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.290618	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.169502	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.175213	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0189 HHA CCN: 14-7594	Period: From 07/01/2018 To 06/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 11/25/2019 9:04 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
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
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	2,731,587
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	372,989
13.00	Total PPS Reimbursement - LUPA Episodes		0	86,963
14.00	Total PPS Reimbursement - PEP Episodes		0	34,759
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	133,868
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	6,479
17.00	Total Other Payments		0	-65,160
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	3,301,485
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	3,301,485
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	3,301,485
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	3,301,485
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	3,301,485
31.01	Sequestration adjustment (see instructions)		0	0
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	3,301,485
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider CCN: 14-0189

Period:

Worksheet H-5

HHA CCN: 14-7594

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 amHome 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		3,301,485	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		3,301,485	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		3,301,485	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: 14-0189

Period:

Worksheet 0

Hospice CCN: 14-1599

From 07/01/2018

To 06/30/2019

Date/Time Prepared:
11/25/2019 9:04 am

				Hospice I		11/20/2020 01:04 am	
		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	106,001	106,001	0	106,001	3.00
4.00	ADMINISTRATIVE & GENERAL*	99,859	110,597	210,456	0	210,456	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	115	115	0	115	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	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	248,421	0	248,421	0	248,421	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	45,600	45,600	0	45,600	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	79,314	79,314	0	79,314	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	36,559	0	36,559	0	36,559	13.00
14.00	PHARMACY*	0	326,211	326,211	0	326,211	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	24,780	24,780	0	24,780	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**	687,536	0	687,536	0	687,536	28.00
29.00	LPN/LVN**	14,858	0	14,858	0	14,858	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**	128,382	0	128,382	0	128,382	33.00
34.00	SPIRITUAL COUNSELING**	54,635	0	54,635	0	54,635	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**	107,755	0	107,755	0	107,755	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	185,232	185,232	0	185,232	38.00
39.00	PATIENT TRANSPORTATION**	0	8,293	8,293	0	8,293	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	137	137	0	137	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	59,270	59,270	0	59,270	46.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM *	58,164	0	58,164	0	58,164	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*	182,041	22,651	204,692	0	204,692	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	1,618,210	968,201	2,586,411	0	2,586,411	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: 14-0189

Period:

Worksheet 0

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		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	106,001		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	210,456		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	115		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	248,421		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	45,600		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	79,314		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	36,559		13.00
14.00	PHARMACY*	0	326,211		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	24,780		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	687,536		28.00
29.00	LPN/LVN**	0	14,858		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	128,382		33.00
34.00	SPIRITUAL COUNSELING**	0	54,635		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	107,755		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	185,232		38.00
39.00	PATIENT TRANSPORTATION**	0	8,293		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	137		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	59,270		46.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	58,164		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	204,692		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	2,586,411		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: 14-0189

Period:

Worksheet 0-2

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

					Hospice I	11/23/2019 9:04 am	
		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	657,157	0	657,157	0	657,157	28.00
29.00	LPN/LVN	14,648	0	14,648	0	14,648	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	122,755	0	122,755	0	122,755	33.00
34.00	SPIRITUAL COUNSELING	52,990	0	52,990	0	52,990	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	107,130	0	107,130	0	107,130	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	185,232	185,232	0	185,232	38.00
39.00	PATIENT TRANSPORTATION	0	4,158	4,158	0	4,158	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	137	137	0	137	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	2,104	2,104	0	2,104	46.00
100.00	TOTAL *	954,680	191,631	1,146,311	0	1,146,311	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	657,157	28.00
29.00	LPN/LVN	0	14,648	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	122,755	33.00
34.00	SPIRITUAL COUNSELING	0	52,990	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	107,130	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	185,232	38.00
39.00	PATIENT TRANSPORTATION	0	4,158	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	137	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	2,104	46.00
100.00	TOTAL *	0	1,146,311	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: 14-0189

Period:

Worksheet 0-3

Hospice CCN: 14-1599

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

Date/Time Prepared:

11/25/2019 9:04 am

				Hospice I			
		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	21,367	0	21,367	0	21,367	28.00
29.00	LPN/LVN	210	0	210	0	210	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	4,696	0	4,696	0	4,696	33.00
34.00	SPIRITUAL COUNSELING	1,487	0	1,487	0	1,487	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	582	0	582	0	582	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	4,135	4,135	0	4,135	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	13,309	13,309	0	13,309	46.00
100.00	TOTAL *	28,342	17,444	45,786	0	45,786	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	21,367	28.00
29.00	LPN/LVN	0	210	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	4,696	33.00
34.00	SPIRITUAL COUNSELING	0	1,487	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	582	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	4,135	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	13,309	46.00
100.00	TOTAL *	0	45,786	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: 14-0189	Period: From 07/01/2018	Worksheet 0-4
		Hospice CCN: 14-1599	To 06/30/2019	Date/Time Prepared: 11/25/2019 9:04 am

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFICATIONS	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	9,012	0	9,012	0	9,012	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	931	0	931	0	931	33.00
34.00	SPIRITUAL COUNSELING	158	0	158	0	158	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	43	0	43	0	43	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	43,857	43,857	0	43,857	46.00
100.00	TOTAL *	10,144	43,857	54,001	0	54,001	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	9,012	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	931	33.00
34.00	SPIRITUAL COUNSELING	0	158	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	43	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	43,857	46.00
100.00	TOTAL *	0	54,001	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: 14-0189

Period:

Worksheet 0-5

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

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	18,334	18,334	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	623	623	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	106,001	386,186	492,187	3.00
4.00	ADMINISTRATIVE & GENERAL	210,456	529,618	740,074	4.00
5.00	PLANT OPERATION & MAINTENANCE	115	21,788	21,903	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	5,722	5,722	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	248,421	0	248,421	9.00
10.00	ROUTINE MEDICAL SUPPLIES	45,600	0	45,600	10.00
11.00	MEDICAL RECORDS	0	21,662	21,662	11.00
12.00	STAFF TRANSPORTATION	79,314	0	79,314	12.00
13.00	VOLUNTEER SERVICE COORDINATION	36,559	0	36,559	13.00
14.00	PHARMACY	326,211	0	326,211	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	24,780	0	24,780	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	1,146,311	0	1,146,311	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	45,786	0	45,786	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	54,001	0	54,001	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	58,164	0	58,164	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	204,692	0	204,692	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	2,586,411	983,933	3,570,344	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189

Period:

Worksheet 0-6

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 9:04 am

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	18,334	18,334					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	623		623				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	492,187	0	0	492,187			3.00
4.00	ADMINISTRATIVE & GENERAL	740,074	18,334	623	492,187		1,251,218	4.00
5.00	PLANT OPERATION & MAINTENANCE	21,903	0	0	0		21,903	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0		0	6.00
7.00	HOUSEKEEPING	5,722	0	0	0		5,722	7.00
8.00	DIETARY	0	0	0	0		0	8.00
9.00	NURSING ADMINISTRATION	248,421	0	0	0		248,421	9.00
10.00	ROUTINE MEDICAL SUPPLIES	45,600	0	0	0		45,600	10.00
11.00	MEDICAL RECORDS	21,662	0	0	0		21,662	11.00
12.00	STAFF TRANSPORTATION	79,314	0	0	0		79,314	12.00
13.00	VOLUNTEER SERVICE COORDINATION	36,559	0	0	0		36,559	13.00
14.00	PHARMACY	326,211	0	0	0		326,211	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	24,780	0	0	0		24,780	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	1,146,311			0		1,146,311	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	45,786	0	0	0		45,786	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	54,001	0	0	0		54,001	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	58,164	0	0	0		58,164	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	204,692	0	0	0		204,692	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	3,570,344	18,334	623	492,187		3,570,344	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189

Period:

Worksheet 0-6

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 9:04 am

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	1,251,218						4.00
5.00	PLANT OPERATION & MAINTENANCE	11,817	33,720					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	3,087	0			8,809		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	134,028	33,720			8,809		9.00
10.00	ROUTINE MEDICAL SUPPLIES	24,602	0			0		10.00
11.00	MEDICAL RECORDS	11,687	0			0		11.00
12.00	STAFF TRANSPORTATION	42,792	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	19,724	0			0		13.00
14.00	PHARMACY	175,998	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	13,369	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						50.00
51.00	HOSPICE ROUTINE HOME CARE	618,459						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	24,703	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	29,135	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	31,381	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	110,436	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	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	1,251,218	33,720		0	8,809		100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189

Period:

Worksheet 0-6

Hospice CCN: 14-1599

From 07/01/2018

Part I

To 06/30/2019

Date/Time Prepared:

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Descriptions		Hospice I				
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	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	424,978				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	70,202			10.00
11.00	MEDICAL RECORDS	0		33,349		11.00
12.00	STAFF TRANSPORTATION	0			122,106	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	56,283 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	421,914	69,696	33,109	121,226	55,876 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,675	277	131	481	217 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,389	229	109	399	190 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	424,978	70,202	33,349	122,106	56,283 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0189

Period:

Worksheet 0-6

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/25/2019 9:04 am

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	502,209					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	38,149				15.00
16.00	OTHER GENERAL SERVICE	0		0			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	498,589	37,874	0		3,003,054	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,979	150	0	0	75,399	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1,641	125	0	0	87,218	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		89,545	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		315,128	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		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	502,209	38,149	0	0	3,570,344	100.00

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

Provider CCN: 14-0189

Period:

Worksheet 0-6

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
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Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,500					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		522				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	1,618,210			3.00
4.00	ADMINISTRATIVE & GENERAL	1,500	522	1,618,210	-1,251,218	2,319,126	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	21,903	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	5,722	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	248,421	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	45,600	10.00
11.00	MEDICAL RECORDS	0	0	0	0	21,662	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	79,314	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	36,559	13.00
14.00	PHARMACY	0	0	0	0	326,211	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	24,780	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	1,146,311	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	45,786	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	54,001	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	58,164	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	204,692	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
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	18,334	623	492,187		1,251,218	100.00
101.00	UNIT COST MULTIPLIER	12.222667	1.193487	0.304155		0.539521	101.00

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

Provider CCN: 14-0189

Period:

Worksheet 0-6

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
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Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (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	1,500					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		1,500			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	1,500		1,500		20,811	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	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	50.00
51.00	HOSPICE ROUTINE HOME CARE					20,661	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	82	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	68	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	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	33,720	0	8,809	0	424,978	100.00
101.00	UNIT COST MULTIPLIER	22.480000	0.000000	5.872667	0.000000	20.420835	101.00

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

Provider CCN: 14-0189

Period:

Worksheet 0-6

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
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Cost Center Descriptions		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	20,811						10.00
11.00	MEDICAL RECORDS		20,811					11.00
12.00	STAFF TRANSPORTATION				20,811			12.00
13.00	VOLUNTEER SERVICE COORDINATION				0	2,075		13.00
14.00	PHARMACY				0	0	20,811	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	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	20,661	20,661	20,661	2,060	2,060	20,661	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	82	82	82	8	8	82	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	68	68	68	7	7	68	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							99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	70,202	33,349	122,106	56,283	56,283	502,209	100.00
101.00	UNIT COST MULTIPLIER	3.373312	1.602470	5.867378	27.124337	27.124337	24.131901	101.00

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

Provider CCN: 14-0189

Period:

Worksheet 0-6

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/25/2019 9:04 am

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	20,811				15.00
16.00	OTHER GENERAL SERVICE		0			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	20,661	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	82	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	68	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		0			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)	38,149	0	0		100.00
101.00	UNIT COST MULTIPLIER	1.833117	0.000000	0.000000		101.00

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

Provider CCN: 14-0189

Period:

Worksheet 0-7

Hospice CCN: 14-1599

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

Date/Time Prepared:
11/25/2019 9:04 am

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	0.226321	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.288344	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.290618	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.175213	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.231824	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.169502	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.351567	0	0	0	9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	5.134784	0	0	0	10.00
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	0	0	0	0	0	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
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0189

Period:

Worksheet 0-8

Hospice CCN: 14-1599

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		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)			3,003,054	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			20,661	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			145.35	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	19,516	93		9.00
10.00	Program cost (line 8 times line 9)	2,836,651	13,518		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)			75,399	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			82	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			919.50	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	69	0		14.00
15.00	Program cost (line 13 times line 14)	63,446	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)			87,218	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			68	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			1,282.62	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	59	0		19.00
20.00	Program cost (line 18 times line 19)	75,675	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			3,165,671	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			20,811	22.00
23.00	Average cost per diem (line 21 divided by line 22)			152.12	23.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0189	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/25/2019 9:04 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,716,995	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		26,971	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)		49.92	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)		1,743,966	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: 14-0189

Period:

Worksheet M-1

Component CCN: 14-3978

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		RHC I		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	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	24,001	348	24,349	0	24,349
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	34,313	3,629	37,942	0	37,942
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	0	0	0	0	0
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	29,615	1,000	30,615	0	30,615
10.00 Subtotal (sum of lines 1 through 9)	87,929	4,977	92,906	0	92,906
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	8,201	8,201	0	8,201
16.00 Transportation (Health Care Staff)	0	419	419	0	419
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	1,046	1,046	0	1,046
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	9,666	9,666	0	9,666
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	87,929	14,643	102,572	0	102,572
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	24,333	24,333	0	24,333
30.00 Administrative Costs	4,592	280	4,872	0	4,872
31.00 Total Facility Overhead (sum of lines 29 and 30)	4,592	24,613	29,205	0	29,205
32.00 Total facility costs (sum of lines 22, 28 and 31)	92,521	39,256	131,777	0	131,777

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-3978

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	24,349		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	37,942		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	30,615		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	92,906		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	8,201		15.00
16.00	Transportation (Health Care Staff)	0	419		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	1,046		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	9,666		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	102,572		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	24,333		29.00
30.00	Administrative Costs	0	4,872		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	29,205		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	131,777		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-3998

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

						RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
	FACILITY HEALTH CARE STAFF COSTS								
1.00	Physician	0	0	0	0	0	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	187,556	16,053	203,609	0	203,609	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	0	0	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	85,514	4,499	90,013	0	90,013	9.00		
10.00	Subtotal (sum of lines 1 through 9)	273,070	20,552	293,622	0	293,622	10.00		
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00		
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00		
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00		
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00		
15.00	Medical Supplies	0	33,393	33,393	0	33,393	15.00		
16.00	Transportation (Health Care Staff)	0	724	724	0	724	16.00		
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00		
18.00	Professional Liability Insurance	0	6,279	6,279	0	6,279	18.00		
19.00	Other Health Care Costs	0	0	0	0	0	19.00		
20.00	Allowable GME Costs						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	40,396	40,396	0	40,396	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	273,070	60,948	334,018	0	334,018	22.00		
	COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
	FACILITY OVERHEAD								
29.00	Facility Costs	0	43,395	43,395	0	43,395	29.00		
30.00	Administrative Costs	47,492	3,057	50,549	0	50,549	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	47,492	46,452	93,944	0	93,944	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	320,562	107,400	427,962	0	427,962	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-3998

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		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	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	203,609	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	90,013	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	293,622	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	33,393	15.00
16.00	Transportation (Health Care Staff)	0	724	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	6,279	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	40,396	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	334,018	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	43,395	29.00
30.00	Administrative Costs	0	50,549	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	93,944	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	427,962	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-3435

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	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	223,941	14,747	238,688	0	238,688
2.00	Physician Assistant	198,000	9,315	207,315	0	207,315
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	151,858	5,072	156,930	0	156,930
10.00	Subtotal (sum of lines 1 through 9)	573,799	29,134	602,933	0	602,933
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	23,379	23,379	0	23,379
16.00	Transportation (Health Care Staff)	0	2,548	2,548	0	2,548
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	10,988	10,988	0	10,988
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	36,915	36,915	0	36,915
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	573,799	66,049	639,848	0	639,848
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	36,645	36,645	0	36,645
30.00	Administrative Costs	44,676	3,876	48,552	0	48,552
31.00	Total Facility Overhead (sum of lines 29 and 30)	44,676	40,521	85,197	0	85,197
32.00	Total facility costs (sum of lines 22, 28 and 31)	618,475	106,570	725,045	0	725,045

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-3435

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		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	238,688	1.00
2.00	Physician Assistant	0	207,315	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	156,930	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	602,933	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	23,379	15.00
16.00	Transportation (Health Care Staff)	0	2,548	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	10,988	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	36,915	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	639,848	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	36,645	29.00
30.00	Administrative Costs	0	48,552	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	85,197	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	725,045	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-8541

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		RHC IV		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	198,991	22,770	221,761	0	221,761 3.00
4.00	Visiting Nurse	146,111	7,117	153,228	0	153,228 4.00
5.00	Other Nurse	0	0	0	0	0 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	345,102	29,887	374,989	0	374,989 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	52,914	52,914	0	52,914 15.00
16.00	Transportation (Health Care Staff)	0	615	615	0	615 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	6,279	6,279	0	6,279 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	59,808	59,808	0	59,808 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	345,102	89,695	434,797	0	434,797 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	34,977	34,977	0	34,977 29.00
30.00	Administrative Costs	63,989	4,954	68,943	0	68,943 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	63,989	39,931	103,920	0	103,920 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	409,091	129,626	538,717	0	538,717 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-8541

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

RHC IV

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	221,761	3.00
4.00	Visiting Nurse	0	153,228	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	374,989	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	52,914	15.00
16.00	Transportation (Health Care Staff)	0	615	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	6,279	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	59,808	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	434,797	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	34,977	29.00
30.00	Administrative Costs	0	68,943	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	103,920	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	538,717	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-8555

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		RHC V		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	476,918	25,377	502,295	0	502,295
2.00	Physician Assistant	72,304	8,111	80,415	0	80,415
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	122,937	3,130	126,067	0	126,067
10.00	Subtotal (sum of lines 1 through 9)	672,159	36,618	708,777	0	708,777
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	84,843	84,843	0	84,843
16.00	Transportation (Health Care Staff)	0	1,656	1,656	0	1,656
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	18,837	18,837	0	18,837
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	105,336	105,336	0	105,336
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	672,159	141,954	814,113	0	814,113
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	53,108	53,108	0	53,108
30.00	Administrative Costs	312,763	23,401	336,164	0	336,164
31.00	Total Facility Overhead (sum of lines 29 and 30)	312,763	76,509	389,272	0	389,272
32.00	Total facility costs (sum of lines 22, 28 and 31)	984,922	218,463	1,203,385	0	1,203,385

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0189

Period:

Worksheet M-1

Component CCN: 14-8555

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

RHC V

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	502,295	1.00
2.00	Physician Assistant	0	80,415	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	126,067	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	708,777	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	84,843	15.00
16.00	Transportation (Health Care Staff)	0	1,656	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	18,837	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	105,336	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	814,113	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	53,108	29.00
30.00	Administrative Costs	0	336,164	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	389,272	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,203,385	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189

Period:

Worksheet M-2

Component CCN: 14-3978

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.08	209	4,200	336		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.22	694	2,100	462		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.30	903		798	903	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)	0.30	903			903	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)					102,572	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)					102,572	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)					29,205	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					115,252	15.00
16.00	Total overhead (sum of lines 14 and 15)					144,457	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					144,457	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					144,457	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					247,029	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189

Period:

Worksheet M-2

Component CCN: 14-3998

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		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	0.00	0	0	1.00
2.00	Physician Assistant	0.00	0	0	2.00
3.00	Nurse Practitioner	1.39	2,753	4,200	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.39	2,753	5,838	4.00
5.00	Visiting Nurse	0.00	0	5,838	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)	1.39	2,753	5,838	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)			334,018	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)			334,018	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)			93,944	14.00
15.00	Parent provider overhead allocated to facility (see instructions)			328,469	15.00
16.00	Total overhead (sum of lines 14 and 15)			422,413	16.00
17.00	Allowable GME overhead (see instructions)			0	17.00
18.00	Enter the amount from line 16			422,413	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)			422,413	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)			756,431	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189

Period:

Worksheet M-2

Component CCN: 14-3435

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

				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	0.58	1,951	4,200	2,436		1.00
2.00	Physician Assistant	0.50	2,809	2,100	1,050		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.08	4,760		3,486	4,760	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)	1.08	4,760			4,760	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)					639,848	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)					639,848	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)					85,197	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					373,828	15.00
16.00	Total overhead (sum of lines 14 and 15)					459,025	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					459,025	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					459,025	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,098,873	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189

Period:

Worksheet M-2

Component CCN: 14-8541

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

		RHC IV		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	0.00	0	0	1.00
2.00	Physician Assistant	0.00	0	0	2.00
3.00	Nurse Practitioner	1.02	4,222	2,100	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.02	4,222	2,142	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)	1.02	4,222		8.00
9.00	Physician Services Under Agreements		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)			434,797	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)			434,797	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)			103,920	14.00
15.00	Parent provider overhead allocated to facility (see instructions)			278,961	15.00
16.00	Total overhead (sum of lines 14 and 15)			382,881	16.00
17.00	Allowable GME overhead (see instructions)			0	17.00
18.00	Enter the amount from line 16			382,881	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)			382,881	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)			817,678	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0189

Period:

Worksheet M-2

Component CCN: 14-8555

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/25/2019 9:04 am

				RHC V		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	1.45	8,230	4,200	6,090		1.00
2.00	Physician Assistant	0.56	2,159	2,100	1,176		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.01	10,389		7,266	10,389	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)	2.01	10,389			10,389	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)					814,113	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)					814,113	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)					389,272	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					693,209	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,082,481	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,082,481	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,082,481	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,896,594	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0189 Component CCN: 14-3978	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/25/2019 9:04 am		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			247,029	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			41	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			246,988	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			903	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)			903	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			273.52	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			83.45	84.70	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			235	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			19,611	0	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	19,611	16.00
16.01	Total program charges (see instructions)(from contractor's records)				28,676	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.)				14,927	16.04
16.05	Total program cost (see instructions)			0	14,927	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				952	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				5,545	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				14,927	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				41	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				14,968	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	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)				14,968	26.00
26.01	Sequestration adjustment (see instructions)				299	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				14,600	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)				69	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: 14-0189 Component CCN: 14-3998	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/25/2019 9:04 am	
		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)			756,431	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			5,831	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			750,600	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,838	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)			5,838	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			128.57	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		455	202	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		37,970	17,109	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	55,079	16.00
16.01	Total program charges (see instructions)(from contractor's records)			84,553	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.)			33,530	16.04
16.05	Total program cost (see instructions)		0	33,530	16.05
17.00	Primary payer amounts			51	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			13,167	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			14,277	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			33,479	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			2,012	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			35,491	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	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)			35,491	26.00
26.01	Sequestration adjustment (see instructions)			710	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			32,161	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			2,620	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: 14-0189 Component CCN: 14-3435	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/25/2019 9:04 am		
		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)			1,098,873	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			4,887	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,093,986	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,760	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)			4,760	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			229.83	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			83.45	84.70	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			1,169	630	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			97,553	53,361	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	150,914	16.00
16.01	Total program charges (see instructions)(from contractor's records)				240,940	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.)				96,276	16.04
16.05	Total program cost (see instructions)			0	96,276	16.05
17.00	Primary payer amounts				169	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				30,569	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				42,074	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				96,107	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				2,726	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				98,833	22.00
23.00	Allowable bad debts (see instructions)				0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	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)				98,833	26.00
26.01	Sequestration adjustment (see instructions)				1,977	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				92,355	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)				4,501	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: 14-0189 Component CCN: 14-8541	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/25/2019 9:04 am	
		Title XVIII	RHC IV	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)			817,678	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			9,899	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			807,779	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			4,222	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)			4,222	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			191.33	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		559	282	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		46,649	23,885	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	70,534	16.00
16.01	Total program charges (see instructions)(from contractor's records)			116,719	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.)			43,816	16.04
16.05	Total program cost (see instructions)		0	43,816	16.05
17.00	Primary payer amounts			46	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			15,764	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			20,191	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			43,770	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			1,861	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			45,631	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	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)			45,631	26.00
26.01	Sequestration adjustment (see instructions)			913	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			42,209	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			2,509	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: 14-0189 Component CCN: 14-8555	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/25/2019 9:04 am	
		Title XVIII	RHC V	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,896,594	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			15,469	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,881,125	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,389	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)			10,389	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			181.07	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		83.45	84.70	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		1,977	858	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		164,981	72,673	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	237,654	16.00
16.01	Total program charges (see instructions)(from contractor's records)			364,459	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.)			154,822	16.04
16.05	Total program cost (see instructions)		0	154,822	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			44,126	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			64,069	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			154,822	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			4,192	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			159,014	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	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)			159,014	26.00
26.01	Sequestration adjustment (see instructions)			3,180	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			149,184	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)			6,650	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: 14-0189 Component CCN: 14-3978	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 9:04 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		92,906	92,906	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	17	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	17	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		102,572	102,572	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		144,457	144,457	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.000166	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	24	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	41	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	1	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	41.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	41	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)			41	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)			41	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0189 Component CCN: 14-3998	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 9:04 am	
		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)		293,622	293,622	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		110	2,465	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		110	2,465	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		334,018	334,018	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		422,413	422,413	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000329	0.007380	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		139	3,117	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		249	5,582	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		2	145	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		124.50	38.50	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		1	49	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		125	1,887	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)			5,831	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)			2,012	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0189 Component CCN: 14-3435	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 9:04 am	
		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)		602,933	602,933	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		550	2,295	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		550	2,295	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		639,848	639,848	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		459,025	459,025	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000860	0.003587	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		395	1,647	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		945	3,942	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		10	135	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		94.50	29.20	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		10	61	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		945	1,781	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)			4,887	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)			2,726	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0189 Component CCN: 14-8541	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 9:04 am	
		Title XVIII	RHC IV	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		374,989	374,989	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		385	4,879	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		385	4,879	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		434,797	434,797	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		382,881	382,881	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000885	0.011221	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		339	4,296	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		724	9,175	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		7	287	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		103.43	31.97	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		1	55	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		103	1,758	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)			9,899	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)			1,861	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0189 Component CCN: 14-8555	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/25/2019 9:04 am	
		Title XVIII	RHC V	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		708,777	708,777	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		385	6,255	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		385	6,255	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		814,113	814,113	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,082,481	1,082,481	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000473	0.007683	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		512	8,317	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		897	14,572	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		7	310	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		128.14	47.01	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		3	81	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		384	3,808	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)			15,469	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)			4,192	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0189 Component CCN: 14-3978	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 9:04 am
		RHC I	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		14,600	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)		14,600	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		69	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		14,669	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: 14-0189 Component CCN: 14-3998	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 9:04 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		32,161	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)		32,161	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		2,620	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		34,781	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: 14-0189 Component CCN: 14-3435	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 9:04 am
		RHC III	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		92,355	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)		92,355	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		4,501	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		96,856	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: 14-0189 Component CCN: 14-8541	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 9:04 am	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			42,209	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)			42,209	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			2,509	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			44,718	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: 14-0189 Component CCN: 14-8555	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/25/2019 9:04 am
		RHC V	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		149,184	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)		149,184	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		6,650	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		155,834	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00

SPECIAL REPORTS - PSYCH RATE REPORT

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet PSYCH
RATE REPORT
Date/Time Prepared:
11/25/2019 9:04 am

		Hospital	PPS	
			1.00	
PSYCH RATIO OF COST TO CHARGES (RCC) REPORT (PER CR7609)				
1.00	Total program cost (D-1 Pt II Line 49.00 minus E-3 Pt II line 28)		1,795,025	1.00
2.00	Total program charges (D-3 Col 2 sum of lines 30-35 if hospital or line 40 if sub-provider plus D-3 Col 2 Line 202; where possible, these charges should be confirmed with the PS&R data)		3,567,972	2.00
3.00	Psych unit Ratio of Cost to Charges (Line 1 divided by line 2)		0.503	3.00
PSYCH RESIDENTS TO AVERAGE DAILY CENSUS REPORT				
11.00	W/S E-3, Pt II Line 8 I&R PPS Med Ed Adj		0.00	11.00
12.00	W/S E-3, Pt II Line 9 Ave Daily Census		13.531507	12.00
13.00	Psych Residents Average Daily Census		0.0000	13.00
PSYCH NATIONAL URBAN & RURAL COST TO CHARGE RATIOS FOR THE IPF PPS FY 2020 (PER CR#11420)				
21.00	Urban Median		0.4370	21.00
22.00	Urban Ceiling		1.7263	22.00
23.00	Rural Median		0.5720	23.00
24.00	Rural Ceiling		2.0239	24.00
BED SIZE				
31.00	Bed Size (W/S S-3, Pt I Col 2 Line 1 (Hospital) or Line 16 (Subprovider))		20.00	31.00

SPECIAL REPORTS - OPPS RCC REPORT WITH PARAMED. ED & ALLIED HEALTH
COSTS EXCLUDED

Provider CCN: 14-0189

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

Worksheet OPPS RCC

Date/Time Prepared:
11/25/2019 9:04 am

Cost Center Description		Cost/Charge Ratio	PPS Services FYB to 12/31	PPS Services 1/1 to FYE	Total Charges (C)	Total Costs (C)	
		1.00	2.00	2.01	3.00	4.00	
ANCILLARY SERVICE COST CENTERS (B)							
50.00	OPERATING ROOM	0.231583	23,421,812	0	23,421,812	5,424,093	50.00
51.00	RECOVERY ROOM	0.221693	2,535,951	0	2,535,951	562,203	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.213173	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.166666	3,786,132	0	3,786,132	631,019	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.196648	11,740,356	0	11,740,356	2,308,718	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.351567	5,382,738	0	5,382,738	1,892,393	55.00
56.00	RADIOISOTOPE	0.107404	9,467,307	0	9,467,307	1,016,827	56.00
57.00	CT SCAN	0.025236	19,962,343	0	19,962,343	503,770	57.00
58.00	MRI	0.059193	7,883,529	0	7,883,529	466,650	58.00
59.00	CARDIAC CATHETERIZATION	0.122033	7,238,771	0	7,238,771	883,369	59.00
60.00	LABORATORY	0.231824	5,231,760	0	5,231,760	1,212,848	60.00
65.00	RESPIRATORY THERAPY	0.172667	868,355	0	868,355	149,936	65.00
66.00	PHYSICAL THERAPY (C)	0.226321	484,505	0	484,505	109,654	66.00
67.00	OCCUPATIONAL THERAPY (C)	0.288344	45,157	0	45,157	13,021	67.00
68.00	SPEECH PATHOLOGY (C)	0.290618	335,563	0	335,563	97,521	68.00
69.00	ELECTROCARDIOLOGY	0.330020	2,618,291	0	2,618,291	864,088	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.541253	558,129	0	558,129	302,089	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0.169502	5,355,811	0	5,355,811	907,821	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.335836	3,948,026	0	3,948,026	1,325,889	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.175213	48,352,585	0	48,352,585	8,472,001	73.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5.134784	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC (C)	2.587558	0	0	0	0	88.00
88.01	RURAL HEALTH CLINIC II (C)	2.179577	0	0	0	0	88.01
88.02	RURAL HEALTH CLINIC III (C)	1.819167	0	0	0	0	88.02
88.03	RURAL HEALTH CLINIC IV (C)	1.414528	0	0	0	0	88.03
88.04	RURAL HEALTH CLINIC V (C)	1.440912	0	0	0	0	88.04
91.00	EMERGENCY	0.182690	14,790,448	0	14,790,448	2,702,067	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.018007	3,783,202	0	3,783,202	3,851,326	92.00
202.00	Total		176,925,546	0	176,925,546	33,477,107	202.00
RCC Calculation (B)							
211.00	Total Cost (Col 4, Line 202 which equals D Pt V col 5, Line 200)					33,477,107	211.00
212.00	Total Charges (Col 3, Line 202 which equals D Pt V col 2 and subscripts, Line 200)					176,925,546	212.00
Cost Center Description					Flagged	Total Costs (C)	
					3.00	4.00	
213.00	OPPS / Charge Ratio (OPPS Cost/Charge Ratio Max is 1.700)					0.189	213.00
Statewide Average Operating RCC							
214.00	Urban					0.211	214.00
215.00	Rural					0.206	215.00
Section II - Bed Size							
221.00	Bed Size (E Pt A line 4 logic)					64.04	221.00
Section III - Non Opps RCC for FISS-Core, 41 Screen, Page 3							
231.00	W/S E Part B, line 1, col 1					22,712	231.00
232.00	W/S E Part B line 12, col 1					129,624	232.00
233.00	Non OPPS RCC (line 231 / line 232)					0.175	233.00

(A) Cost/Charge Ratio Calculated after omitting the Costs for Paramed Ed & Allied Health

(B) Worksheet A line numbers. If lines 96-97 present, review to ensure that "Non Implantable DME" is Excluded

(C) Wks A lines 61, 66-68, 74, 88, 89, 94, 95 are not included in Totals

Cost Center Description		Cost/Charge Ratio	FISS DCCR	Total Charges	Total Costs	
		1.00	2.00	3.00	4.00	
Section IV - Implantable Device Cost to Charge (CR9675)						
241.00	Implantable Device CCR - OPSF Field DCCR (W/S C, Part I, Line 72, Column 9)	0.335836	0.336	36,489,429	12,254,453	241.00

SPECIAL REPORTS - COST TO CHARGE RATIO REPORT

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet COST TO
CHARGE RATIO RPT
Date/Time Prepared:
11/25/2019 9:04 am

		1.00	
1.00	Ref:	Change Req #11361 and Fed Reg 8-16-19 pg 42630	1.00
I. COST TO CHARGE RATIO FOR PPS HOSPITALS			
11.00	Total program (Title XVIII) inpatient operating cost excluding capital related, nonphysician anesthetist and medical education cost (Worksheet D-1, Part II, Line 53 minus Line 42 nursery costs)	28,582,683	11.00
12.00	Hospital Part A Title XVIII charges (Sum of routine charges (D-3 col 2 lines 30-35) plus ancillary charges (D-3 col 2 line 202) for hospital Title XVIII component)	102,257,216	12.00
13.00	Ratio of cost to charges (Line 1/Line 2) (Operating Max is 1.155)	0.280	13.00
II. COST TO CHARGE RATIO FOR CAPITAL			
21.00	Total medicare inpatient PPS capital related costs (W/S D Part I, Lines 30-35, column 7; Plus D Part II, Line 200, column 5)	2,498,815	21.00
22.00	Hospital Part A Title XVIII charges (Sum of routine charges (D-3 col 2 lines 30-35) plus ancillary charges (D-3 col 2 line 202) for hospital Title XVIII component)	102,257,216	22.00
23.00	Ratio of cost to charges (Line 21/Line 22) (Capital Max is 0.144)	0.024	23.00
III. MEDICAID PATIENT DAYS TO TOTAL DAYS			
31.00	Medicaid Patient Days (S-2, Part I Columns 1-6 Line 24)	3,998	31.00
32.00	Total Days (S-3, Part I Column 8 Line 14 + Column 8 Line 32 minus sum of Lines 5-6, plus employee discount days Column 8 Line 30)	19,462	32.00
33.00	Medicaid Ratio (Line 1 divided by Line 2)	0.2054	33.00
IV. BED SIZE			
41.00	Bed Size (W/S E, Part A, Line 4 Logic)	64.04	41.00

SPECIAL REPORTS - PASS THRU PER DIEM REPORT

Provider CCN: 14-0189

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

Worksheet Pass Thru

Date/Time Prepared:
11/25/2019 9:04 am

		1.00	
MEDICAL EDUCATION PASS-THRU PER DIEM (PTA EDU)			
1.00	Direct Medical Education (E Pt A lines 52 + 53)	0	1.00
2.00	Medicare Days (E-4 line 26 cols 1 + 2)	0	2.00
3.00	Direct Med Ed Pass-Thru Per Diem (line 1 / line 2)	0.00	3.00
4.00	Routine Service Pass-Thru (E Pt A line 57)	0	4.00
5.00	Ancillary Service Pass-Thru (E Pt A Line 58)	0	5.00
6.00	Total Allied Health Education Costs (line 4 + line 5)	0	6.00
7.00	Medicare Days (S-3 Pt I line 14 col 6)	9,785	7.00
8.00	Allied Health Ed Pass-Thru Per Diem (line 6 / line 7)	0.00	8.00
9.00	Total Medical Education Pass-Thru Per Diem (line 3 + line 8)	0.00	9.00
ORGAN ACQUISITION PASS-THRU PER DIEM (PTA ORG)			
10.00	Net Organ Acquisition Cost (E Pt A line 55)	0	10.00
11.00	Medicare Days (S-3 Pt I line 14 col 6)	9,785	11.00
12.00	Organ Acquisition Pass-Thru Per Diem (line 10 / line 11)	0.00	12.00
13.00	Total Pass-Thru Per Diem (line 9 + line 12)	0.00	13.00

SPECIAL REPORTS - HITECH FISS DATA REPORT

Provider CCN: 14-0189

Period:
From 07/01/2018
To 06/30/2019Worksheet HITECH
FISS REPORT
Date/Time Prepared:
11/25/2019 9:04 am

		1.00	
1.00	Acceptance Date		1.00
1.01	Is this a CAH?	NO	1.01
CAH DATA FIELDS:			
2.00	Inpatient Days - Part A (S-3 Pt I col 6, lines 1 + 8-12)		2.00
3.00	Inpatient Days - Part C (S-3 Pt I col 6, line 2)		3.00
4.00	Total I/P Days (S-3 Pt I col 8, lines 1 + 8-12)		4.00
5.00	Total Charges (C Pt I col 8, line 200)		5.00
6.00	Charity Care (S-10 col 3, line 20)		6.00
		1.00	
7.00	Cost of EHR Equipment (obtained from provider)		7.00
		1.00	
NON-CAH DATA FIELDS:			
8.00	Total Discharges (S-3 Pt I col 15, line 14)	0	8.00
9.00	Inpatient Days - Part A (S-3 Pt I col 6, lines 1 + 8-12)	0	9.00
10.00	Inpatient Days - Part C (S-3 Pt I col 6, line 2)	0	10.00
11.00	Total I/P Days (S-3 Pt I col 8, lines 1 + 8-12)	0	11.00
12.00	Total Charges (C Pt I col 8, line 200)	0	12.00
13.00	Charity Care (S-10 col 3, line 20)	0	13.00
		1.00	
14.00	Input into FISS:		14.00
15.00	Date input into FISS:		15.00

SPECIAL REPORTS - HITECH FISS DATA REPORT - FINALIZED REPORT

Provider CCN: 14-0189

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

Worksheet HITECH FI

Date/Time Prepared:
11/25/2019 9:04 am

		1.00	
1.00	Acceptance Date		1.00
1.01	Is this a CAH?	NO	1.01
CAH DATA FIELDS:			
2.00	Inpatient Days - Part A (S-3 Pt I col 6, lines 1 + 8-12)		2.00
3.00	Inpatient Days - Part C (S-3 Pt I col 6, line 2)		3.00
4.00	Total I/P Days (S-3 Pt I col 8, lines 1 + 8-12)		4.00
5.00	Total Charges (C Pt I col 8, line 200)		5.00
6.00	Charity Care (S-10 col 3, line 20)		6.00
		1.00	
7.00	Cost of EHR Equipment (E-1 Pt II, line 7)		7.00
		1.00	
NON-CAH DATA FIELDS:			
8.00	Total Discharges (S-3 Pt I col 15, line 14)	0	8.00
9.00	Inpatient Days - Part A (S-3 Pt I col 6, lines 1 + 8-12)	0	9.00
10.00	Inpatient Days - Part C (S-3 Pt I col 6, line 2)	0	10.00
11.00	Total I/P Days (S-3 Pt I col 8, lines 1 + 8-12)	0	11.00
12.00	Total Charges (C Pt I col 8, line 200)	0	12.00
13.00	Charity Care (S-10 col 3, line 20)	0	13.00
		1.00	
14.00	Input into FISS:		14.00
15.00	Date input into FISS:		15.00
16.00	Pymt Yr:		16.00
17.00	NPI No.:		17.00
18.00	Base Amt:	2,000,000	18.00
19.00	Pymt Cat:		19.00
20.00	Prepared by:		20.00
21.00	Audit Case Number:		21.00