

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: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/27/2019 11:55 am
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PART I - COST REPORT STATUS			
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.		
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 HARRISBURG MEDICAL CENTER, INC. (14-0210) 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) DONALD HUTSON
 Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-6,148	-44,731	0	0	1.00
2.00	Subprovider - IPF	0	-30,675	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-37		0	9.00
10.00	RURAL HEALTH CLINIC I	0		107,118		0	10.00
10.01	RURAL HEALTH CLINIC II	0		488		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-4,104		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		-91,514		0	10.03
10.04	RURAL HEALTH CLINIC V	0		91,879		0	10.04
200.00	Total	0	-36,823	59,099	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0210		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/27/2019 11:55 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 100 DR WARREN TUTTLE DRIVE			PO Box:				1.00		
2.00	City: HARRISBURG			State: IL		Zip Code: 62946		County: SALINE		
		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		HARRISBURG MEDICAL CENTER, INC.	140210	99914	1	07/01/1966	N	P	N
4.00	Subprovider - IPF		HARRISBURG MEDICAL CENTER, INC.	14S210	99914	4	06/19/1989	N	P	N
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		HARRISBURG MEDICAL CENTER, INC.	14U210	99914		11/03/1988	N	P	N
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		HARRISBURG MEDICAL CENTER, INC.	147419	99914		08/15/1985	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		ELDORADO PRIMARY CARE	143473	99914		12/31/2001	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		EQUALITY FAMILY PRACTICE	148518	99914		09/27/2011	N	O	N
15.02	Hospital-Based Health Clinic - RHC III		GALATIA PRIMARY CARE	148560	99914		05/10/2016	N	O	N
15.03	Hospital-Based Health Clinic - RHC IV		HMC AT HARRISBURG	148589	99914		06/05/2018	N	O	N
15.04	Hospital-Based Health Clinic - RHC V		HARRISBURG MEDICAL CENTER	148590	99914		06/05/2018	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		20.00
21.00	Type of Control (see instructions)						2			21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00	

Worksheet S-2
Part I
Date/Time Prepared:
11/27/2019 11:55 am

MCRIF32 - 15.9.167.1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0210		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/27/2019 11:55 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: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/27/2019 11:55 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	
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N N 0	76.00

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

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		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.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	92,641	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: 14-0210		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/27/2019 11:55 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 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning 1.00	Ending 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)					01/01/2018	03/31/2018		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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/27/2019 11:55 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	
			1.00	2.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2018	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/18/2019	Y	10/18/2019
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: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/27/2019 11:55 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		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.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSENALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/27/2019 11:55 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/27/2019 11:55 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	40	14,600	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)		40	14,600	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		40	14,600	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	30	10,950		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						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 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)		70				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: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/27/2019 11:55 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)	2,962	105	4,671			1.00
2.00	HMO and other (see instructions)	483	643				2.00
3.00	HMO IPF Subprovider	118	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	133	0	145			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	15			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,095	105	4,831			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)	3,095	105	4,831	0.00	389.30	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,910	4,626	9,274	0.00	55.47	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	1,302	0	2,189	0.00	7.58	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	5,044	0	17,766	0.00	16.37	26.00
26.01	RURAL HEALTH CLINIC II	53	0	259	0.00	2.77	26.01
26.02	RURAL HEALTH CLINIC III	435	0	2,288	0.00	2.54	26.02
26.03	RURAL HEALTH CLINIC IV	3,275	0	13,061	0.00	12.21	26.03
26.04	RURAL HEALTH CLINIC V	3,786	0	13,287	0.00	13.82	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	500.06	27.00
28.00	Observation Bed Days		0	1,411			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/27/2019 11:55 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	937	243	1,547	1.00
2.00 HMO and other (see instructions)			146	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	937	243	1,547	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	307	648	1,196	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 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: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/27/2019 11:55 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	28,769,839	0	28,769,839	1,066,637.85	26.97	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		727,830	0	727,830	6,480.00	112.32	3.00
4.00	Physician-Part A - Administrative		65,591	0	65,591	522.00	125.65	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		6,153,897	0	6,153,897	50,041.57	122.98	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		1,627,840	-92,615	1,535,225	77,642.59	19.77	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,293,590	-39,816	4,253,774	159,169.43	26.72	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		108,033	0	108,033	1,698.00	63.62	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		11,000	0	11,000	60.00	183.33	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,291,595	0	6,291,595			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,399,380	0	1,399,380			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		98,399	0	98,399			21.00
22.00	Physician Part A - Administrative		8,269	0	8,269			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,409,950	0	1,409,950			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	125,548	0	125,548	7,831.85	16.03	26.00
27.00	Administrative & General	5.00	3,666,865	39,816	3,706,681	151,536.06	24.46	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/27/2019 11:55 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.)		282,346	0	282,346	1,378.53	204.82	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	476,677	0	476,677	29,474.95	16.17	30.00
31.00	Laundry & Linen Service	8.00	48,177	0	48,177	4,196.80	11.48	31.00
32.00	Housekeeping	9.00	545,732	0	545,732	45,420.46	12.02	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	567,030	0	567,030	42,561.29	13.32	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	110,742	0	110,742	4,489.16	24.67	38.00
39.00	Central Services and Supply	14.00	268,946	0	268,946	22,337.58	12.04	39.00
40.00	Pharmacy	15.00	602,699	0	602,699	12,439.73	48.45	40.00
41.00	Medical Records & Medical Records Library	16.00	473,725	0	473,725	24,661.82	19.21	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/27/2019 11:55 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)	20,542,618	92,615	20,635,233	933,852.22	22.10	1.00
2.00	Excluded area salaries (see instructions)	4,293,590	-39,816	4,253,774	159,169.43	26.72	2.00
3.00	Subtotal salaries (line 1 minus line 2)	16,249,028	132,431	16,381,459	774,682.79	21.15	3.00
4.00	Subtotal other wages & related costs (see inst.)	119,033	0	119,033	1,758.00	67.71	4.00
5.00	Subtotal wage-related costs (see inst.)	6,299,864	0	6,299,864	0.00	38.46	5.00
6.00	Total (sum of lines 3 thru 5)	22,667,925	132,431	22,800,356	776,440.79	29.37	6.00
7.00	Total overhead cost (see instructions)	7,168,487	39,816	7,208,303	346,328.23	20.81	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/27/2019 11:55 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		788,457	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		6,097,661	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		87,844	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		34,329	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		234,272	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,532,336	17.00
18.00	Medicare Taxes - Employers Portion Only		358,369	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		45,771	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		28,554	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		9,207,593	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: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/27/2019 11:55 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	108,033	9,207,593	1.00
2.00	Hospital	108,033	9,207,593	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
14.04	Hospital-Based Health Clinic RHC 4	0	0	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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0210 Component CCN: 14-7419		Period: From 07/01/2018 To 06/30/2019		Worksheet S-4 Date/Time Prepared: 11/27/2019 11:55 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			SALINE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	117.00	143.00	196.00	456.00	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)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			2.19	0.00	2.19	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			3.55	0.00	3.55	6.00
7.00	Nursing Supervisor			0.83	0.00	0.83	7.00
8.00	Physical Therapy Service			0.89	0.00	0.89	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.09	0.00	0.09	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.03	0.00	0.03	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	540	0	79	26	645	21.00
22.00	Skilled Nursing Visit Charges	126,900	0	18,565	6,110	151,575	22.00
23.00	Physical Therapy Visits	548	0	10	19	577	23.00
24.00	Physical Therapy Visit Charges	129,328	0	2,360	4,484	136,172	24.00
25.00	Occupational Therapy Visits	55	0	0	0	55	25.00
26.00	Occupational Therapy Visit Charges	14,025	0	0	0	14,025	26.00
27.00	Speech Pathology Visits	23	0	0	2	25	27.00
28.00	Speech Pathology Visit Charges	5,865	0	0	510	6,375	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,166	0	89	47	1,302	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	276,118	0	20,925	11,104	308,147	35.00
36.00	Total Number of Episodes (standard/non outlier)	101		30	4	135	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	8,240	0	2,589	1,537	12,366	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0210

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

Worksheet S-7

Date/Time Prepared:
11/27/2019 11:55 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	11/03/1988		2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	10	10 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	12	12 22.00
23.00		RMA	0	8	8 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	20	20 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	6	6 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	12	12 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	23	23 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0210

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

Worksheet S-7

Date/Time Prepared:
11/27/2019 11:55 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	4	4	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	27	27	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	11	11	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	133	133	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

Health Financial Systems		HARRISBURG MEDICAL CENTER, INC.		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-0210 Component CCN: 14-3473		Period: From 07/01/2018 To 06/30/2019 Worksheet S-8 Date/Time Prepared: 11/27/2019 11:55 am	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	1007 USE ROUTE 45 1.00			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ELDORADO IL 62930 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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1)				
	CLINIC	08:00		20:00 08:00 11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0 13.00	
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	15.00			
		County		4.00	
2.00	City, State, ZIP Code, County	SALINE 2.00			
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
				10.00	
11.00	Facility hours of operations (1)				
	CLINIC	20:00	08:00	20:00	08:00 17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0210 Component CCN: 14-3473		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/27/2019 11:55 am	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			08:00	16:50				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-0210
 Component CCN: 14-8518

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

Worksheet S-8

 Date/Time Prepared:
 11/27/2019 11:55 am

				RHC II		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			183 WEST LN ST		1.00	
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			EQUALITY IL 62934		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00	
			Sunday		Monday		Tuesday
			from	to	from	to	from
			1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)							
11.00	CLINIC			08:00		17:00 08:00 11.00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			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			GALLATIN		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 19:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0210 Component CCN: 14-8518		Period: From 07/01/2018 To 06/30/2019	Worksheet S-8 Date/Time Prepared: 11/27/2019 11:55 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					11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-0210
 Component CCN: 14-8560

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

Worksheet S-8

 Date/Time Prepared:
 11/27/2019 11:55 am

				RHC III		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			124 E MAIN STREET			1.00
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			GALATIA IL 62935		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0	10.00
			Sunday		Monday		Tuesday
			from	to	from	to	from
			1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)							
11.00	CLINIC			08:00		17:00	08:00
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
			Y/N	V	XVIII	XIX	Total Visits
			1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
				County			
				4.00			
2.00	City, State, ZIP Code, County			SALINE		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		17:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-8560

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 am

RHC III

Cost

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

Health Financial Systems		HARRISBURG MEDICAL CENTER, INC.		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-0210 Component CCN: 14-8589		Period: From 07/01/2018 To 06/30/2019
			Worksheet S-8		Date/Time Prepared: 11/27/2019 11:55 am
			RHC IV		Cost
			1.00		
1.00	Clinic Address and Identification				
	Street		901 S COMMERCIAL		1.00
			City	State	ZIP Code
			1.00	2.00	3.00
2.00	City, State, ZIP Code, County		HARRISBURG IL 62946		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
			from	to	from
			1.00	2.00	3.00 4.00
			Tuesday		from
					5.00
11.00	Facility hours of operations (1)				
	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.				0 13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				
			Y/N	V	XVIII
			1.00	2.00	3.00
			XIX		Total Visits
					5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
			County		
			4.00		
2.00	City, State, ZIP Code, County		SALINE		
			Tuesday		Wednesday
			to	from	to
			6.00	7.00	8.00
			Thursday		from
					to
					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: 14-0210 Component CCN: 14-8589	Period: From 07/01/2018 To 06/30/2019	Worksheet S-8 Date/Time Prepared: 11/27/2019 11:55 am	
			RHC IV		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: 14-0210
 Component CCN: 14-8590

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

Worksheet S-8

 Date/Time Prepared:
 11/27/2019 11:55 am

		RHC V		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		3106 OUTER DRIVE STE 300		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		MARION IL 62959		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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)		CLINIC		11.00
		08:00		17:00	
		08:00		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		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
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County		4.00	
2.00	City, State, ZIP Code, County		WILLIAMSON		2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00		11.00	
11.00	Facility hours of operations (1)		CLINIC		11.00
		17:00	08:00	17:00	08:00
		17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0210

Period:

Worksheet S-8

Component CCN: 14-8590

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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 UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0210

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

Worksheet S-10

Date/Time Prepared:
11/27/2019 11:55 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)			0.345572	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			5,713,804	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			4,268,423	5.00
6.00	Medicaid charges			28,573,620	6.00
7.00	Medicaid cost (line 1 times line 6)			9,874,243	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)			0	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)			0	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)	724,535	1,424,843	2,149,378	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	250,379	1,424,843	1,675,222	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	29,376	29,376	22.00
23.00	Cost of charity care (line 21 minus line 22)	250,379	1,395,467	1,645,846	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)			3,113,416	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			484,541	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			745,448	27.01
28.00	Non-Medicare bad debt expense (see instructions)			2,367,968	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,079,210	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,725,056	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,725,056	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0210

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

Worksheet A

Date/Time Prepared:

11/27/2019 11:55 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification 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		3,030,639	3,030,639	-508,092	2,522,547	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,683,499	1,683,499	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,548	9,302,215	9,427,763	0	9,427,763	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,666,865	4,696,346	8,363,211	-83,578	8,279,633	5.00
7.00	00700	OPERATION OF PLANT	476,677	760,015	1,236,692	73,503	1,310,195	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,177	97,078	145,255	0	145,255	8.00
9.00	00900	HOUSEKEEPING	545,732	78,758	624,490	0	624,490	9.00
10.00	01000	DIETARY	567,030	307,024	874,054	0	874,054	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	110,742	5,749	116,491	0	116,491	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268,946	162,182	431,128	0	431,128	14.00
15.00	01500	PHARMACY	602,699	227,519	830,218	0	830,218	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	473,725	366,026	839,751	0	839,751	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	727,830	727,830	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,723,417	908,150	5,631,567	0	5,631,567	30.00
40.00	04000	SUBPROVIDER - IPF	2,434,675	1,199,637	3,634,312	0	3,634,312	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	663,403	479,681	1,143,084	0	1,143,084	50.00
53.00	05300	ANESTHESIOLOGY	998,263	47,673	1,045,936	-727,830	318,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	456,275	194,955	651,230	54,276	705,506	54.00
54.01	05401	ULTRASOUND	206,338	27,157	233,495	0	233,495	54.01
54.02	03440	MAMMOGRAPHY	64,622	63,857	128,479	0	128,479	54.02
56.00	05600	RADIOISOTOPE	161,928	279,038	440,966	0	440,966	56.00
57.00	05700	CT SCAN	185,386	142,546	327,932	0	327,932	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	27,747	96,575	124,322	0	124,322	58.00
60.00	06000	LABORATORY	823,393	1,418,654	2,242,047	38,339	2,280,386	60.00
64.00	06400	INTRAVENOUS THERAPY	0	275	275	0	275	64.00
65.00	06500	RESPIRATORY THERAPY	624,276	147,193	771,469	0	771,469	65.00
66.00	06600	PHYSICAL THERAPY	637,974	17,615	655,589	0	655,589	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,571	5,651	173,222	0	173,222	67.00
68.00	06800	SPEECH PATHOLOGY	31,610	326	31,936	0	31,936	68.00
69.00	06900	ELECTROCARDIOLOGY	93,773	117,605	211,378	0	211,378	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,642,796	1,642,796	-1,497,602	145,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,497,602	1,497,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,315,687	1,315,687	0	1,315,687	73.00
75.00	07500	ASC (NON-DISTINCT PART)	624,988	129,528	754,516	0	754,516	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	129,016	7,723	136,739	0	136,739	76.00
76.97	07697	CARDIAC REHABILITATION	102,112	33,187	135,299	0	135,299	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,438,978	471,287	1,910,265	-131,044	1,779,221	88.00
88.01	08801	RURAL HEALTH CLINIC II	18,939	6,191	25,130	891	26,021	88.01
88.02	08802	RURAL HEALTH CLINIC III	187,072	86,766	273,838	-26,123	247,715	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,145,256	545,985	1,691,241	-18,272	1,672,969	88.03
88.04	08804	RURAL HEALTH CLINIC V	988,763	819,488	1,808,251	-140,457	1,667,794	88.04
91.00	09100	EMERGENCY	3,089,008	377,644	3,466,652	0	3,466,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	282,152	38,959	321,111	-41,256	279,855	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		867,270	867,270	-867,270	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,193,076	30,522,650	57,715,726	34,416	57,750,142	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,490,794	218,438	1,709,232	-16,447	1,692,785	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	41,209	706	41,915	0	41,915	194.01
194.02	07952	FOUNDATION	44,760	128,490	173,250	-17,969	155,281	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	28,769,839	30,870,284	59,640,123	0	59,640,123	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0210

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

Worksheet A

Date/Time Prepared:
11/27/2019 11:55 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	-157,698	2,364,849	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,683,499	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,515,669	7,912,094	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-556,815	7,722,818	5.00
7.00	00700	OPERATION OF PLANT	35	1,310,230	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	145,255	8.00
9.00	00900	HOUSEKEEPING	0	624,490	9.00
10.00	01000	DIETARY	-99,653	774,401	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	116,491	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	431,128	14.00
15.00	01500	PHARMACY	-194,270	635,948	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,550	815,201	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-727,830	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,239,116	3,392,451	30.00
40.00	04000	SUBPROVIDER - IPF	-183,481	3,450,831	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-14,773	1,128,311	50.00
53.00	05300	ANESTHESIOLOGY	-270,433	47,673	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	705,506	54.00
54.01	05401	ULTRASOUND	0	233,495	54.01
54.02	03440	MAMMOGRAPHY	0	128,479	54.02
56.00	05600	RADIOISOTOPE	0	440,966	56.00
57.00	05700	CT SCAN	14	327,946	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	124,322	58.00
60.00	06000	LABORATORY	-3,491	2,276,895	60.00
64.00	06400	INTRAVENOUS THERAPY	0	275	64.00
65.00	06500	RESPIRATORY THERAPY	-48,087	723,382	65.00
66.00	06600	PHYSICAL THERAPY	152	655,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	173,222	67.00
68.00	06800	SPEECH PATHOLOGY	0	31,936	68.00
69.00	06900	ELECTROCARDIOLOGY	-64,993	146,385	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	145,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,497,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,315,687	73.00
75.00	07500	ASC (NON-DISTINCT PART)	103	754,619	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	136,739	76.00
76.97	07697	CARDIAC REHABILITATION	-28,709	106,590	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,779,221	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	26,021	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	247,715	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	1,672,969	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	1,667,794	88.04
91.00	09100	EMERGENCY	-2,148,786	1,317,866	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	279,855	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,278,050	49,472,092	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,692,785	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	194.00
194.01	07951	AUXILIARY	0	41,915	194.01
194.02	07952	FOUNDATION	0	155,281	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,278,050	51,362,073	200.00

RECLASSIFICATIONS

Provider CCN: 14-0210

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

Worksheet A-6

Date/Time Prepared:
11/27/2019 11:55 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXP & BOND AMORT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	867,270		1.00
	0		0	867,270		
	B - MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,631,770		1.00
	0		0	1,631,770		
	D - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	166,865		1.00
	0		0	166,865		
	E - HOME HEALTH BILLERS					
1.00	ADMINISTRATIVE & GENERAL	5.00	39,816	0		1.00
	0		39,816	0		
	F - LAB TECHS					
1.00	LABORATORY	60.00	38,339	0		1.00
	0		38,339	0		
	G - RADIOLOGY TECHS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	54,276	0		1.00
	0		54,276	0		
	I - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO	72.00	0	1,497,602		1.00
	PATIENTS					
	0		0	1,497,602		
	J - CRNA SALARIES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	727,830	0		1.00
	0		727,830	0		
	L - ALLOWABLE ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17,969		1.00
	0		0	17,969		
	M - OVERHEAD COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	141,272		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	34,130		2.00
3.00	OPERATION OF PLANT	7.00	0	73,503		3.00
4.00	RURAL HEALTH CLINIC II	88.01	0	891		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
	TOTALS		0	249,796		
500.00	Grand Total: Increases		860,261	4,431,272		500.00

RECLASSIFICATIONS

Provider CCN: 14-0210

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

Worksheet A-6

Date/Time Prepared:
11/27/2019 11:55 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXP & BOND AMORT						
1.00	INTEREST EXPENSE	113.00	0	867,270	11		1.00
	0		0	867,270			
	B - MME DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		1,631,770	9		1.00
	0		0	1,631,770			
	D - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	166,865	12		1.00
	0		0	166,865			
	E - HOME HEALTH BILLERS						
1.00	HOME HEALTH AGENCY	101.00	39,816	0	0		1.00
	0		39,816	0			
	F - LAB TECHS						
1.00	RURAL HEALTH CLINIC	88.00	38,339	0	0		1.00
	0		38,339	0			
	G - RADIOLOGY TECHS						
1.00	RURAL HEALTH CLINIC	88.00	54,276	0	0		1.00
	0		54,276	0			
	I - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,497,602	0		1.00
	0		0	1,497,602			
	J - CRNA SALARIES						
1.00	ANESTHESIOLOGY	53.00	727,830	0	0		1.00
	0		727,830	0			
	L - ALLOWABLE ADVERTISING						
1.00	FOUNDATION	194.02	0	17,969	0		1.00
	0		0	17,969			
	M - OVERHEAD COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	38,429	10		1.00
2.00	RURAL HEALTH CLINIC III	88.02	0	26,123	0		2.00
3.00	RURAL HEALTH CLINIC IV	88.03	0	18,272	0		3.00
4.00	RURAL HEALTH CLINIC V	88.04	0	140,457	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	1,440	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	16,447	0		6.00
7.00	ADMINISTRATIVE & GENERAL	5.00	0	8,628	0		7.00
	TOTALS		0	249,796			
500.00	Grand Total: Decreases		860,261	4,431,272			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/27/2019 11:55 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	818,193	36,517	0	36,517	15,110	1.00	
2.00	Land Improvements	923,803	3,191	0	3,191	33,102	2.00	
3.00	Buildings and Fixtures	37,234,430	379,046	0	379,046	240,731	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	16,986,601	875,828	0	875,828	292,547	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	55,963,027	1,294,582	0	1,294,582	581,490	8.00	
9.00	Reconciling Items	-180,568	-226,422	0	-226,422	-148,447	9.00	
10.00	Total (line 8 minus line 9)	56,143,595	1,521,004	0	1,521,004	729,937	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	839,600	0					1.00
2.00	Land Improvements	893,892	0					2.00
3.00	Buildings and Fixtures	37,372,745	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	17,569,882	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	56,676,119	0					8.00
9.00	Reconciling Items	-258,543	0					9.00
10.00	Total (line 8 minus line 9)	56,934,662	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/27/2019 11:55 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	3,030,639	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)	3,030,639	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	3,030,639				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	3,030,639				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/27/2019 11:55 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	39,106,237	0	39,106,237	0.689995	115,136	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,569,882	0	17,569,882	0.310005	51,729	2.00
3.00	Total (sum of lines 1-2)	56,676,119	0	56,676,119	1.000000	166,865	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	115,136	1,398,869	141,272	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	51,729	1,631,770	0	2.00
3.00	Total (sum of lines 1-2)	0	0	166,865	3,030,639	141,272	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	709,572	115,136	0	0	2,364,849	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	51,729	0	0	1,683,499	2.00
3.00	Total (sum of lines 1-2)	709,572	166,865	0	0	4,048,348	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0210

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

Worksheet A-8

Date/Time Prepared:
11/27/2019 11:55 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-157,698	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-1,072	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-12,715	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,998,415			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	-99,653	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-24,550	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	-5,479	ADMINISTRATIVE & GENERAL	5.00	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	A	-727,830	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME - A&G	B	-9,751	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0210

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

Worksheet A-8

Date/Time Prepared:
11/27/2019 11:55 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	
33.01	MISC INCOME - ER	B	-3,988	EMERGENCY	91.00	0	33.01
33.02	SIH RESERVE BH INCOME	B	-5,192	SUBPROVIDER - IPF	40.00	0	33.02
33.03	PARKING LOT RENTAL INCOME	B	-12,000	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	CRNA BENEFITS	A	-232,937	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
34.00	PHYSICIAN BENEFITS	A	-1,281,046	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.00
37.00	CAPITALIZED INTEREST	A		OPERATION OF PLANT	7.00	0	37.00
37.01	CAPITALIZED INTEREST	A	77	OPERATING ROOM	50.00	0	37.01
37.02	CAPITALIZED INTEREST	A	14	CT SCAN	57.00	0	37.02
37.03	CAPITALIZED INTEREST	A	152	PHYSICAL THERAPY	66.00	0	37.03
37.04	CAPITALIZED INTEREST	A	103	ASC (NON-DISTINCT PART)	75.00	0	37.04
37.05	CAPITALIZED INTEREST	A	90	EMERGENCY	91.00	0	37.05
38.00	340B RETAIL PHARMACY COSTS	A	-194,270	PHARMACY	15.00	0	38.00
38.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.01
38.02	INSURANCE SETTLEMENTS	A	-180,620	ADMINISTRATIVE & GENERAL	5.00	0	38.02
39.00	COMM RELATIONS	A	-952	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
39.01	COMM RELATIONS	A	-12,648	ADMINISTRATIVE & GENERAL	5.00	0	39.01
39.02	PHYSICIAN RECRUITMENT	A	-241,251	ADMINISTRATIVE & GENERAL	5.00	0	39.02
40.00	PHYSICIAN LOANS	A	-53,572	ADMINISTRATIVE & GENERAL	5.00	0	40.00
40.01	ALCOHOL	A	-132	ADMINISTRATIVE & GENERAL	5.00	0	40.01
40.02	LOBBYING DUES	A	-17,774	ADMINISTRATIVE & GENERAL	5.00	0	40.02
40.03	HR DUES	A	-734	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.03
40.04	ADMIN DUES	A	-2,583	ADMINISTRATIVE & GENERAL	5.00	0	40.04
40.05	BOARD MEMBER EXPENSE	A	-1,659	ADMINISTRATIVE & GENERAL	5.00	0	40.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,278,050				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: 14-0210

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

Worksheet A-8-2

Date/Time Prepared:
11/27/2019 11:55 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	5.00	ADMINISTRATIVE & GENERAL	25,591	0	25,591	211,500	197	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,239,116	2,239,116	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	24,000	0	24,000	181,300	195	3.00
4.00	40.00	SUBPROVIDER - IPF	237,182	0	237,182	181,300	756	4.00
5.00	50.00	OPERATING ROOM	14,850	14,850	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	270,433	270,433	0	0	0	6.00
7.00	60.00	LABORATORY	11,000	0	11,000	260,300	60	7.00
8.00	65.00	RESPIRATORY THERAPY	48,087	48,087	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	64,993	64,993	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	28,709	28,709	0	0	0	10.00
11.00	91.00	EMERGENCY	2,177,935	2,137,935	40,000	211,500	325	11.00
200.00			5,141,896	4,804,123	337,773		1,533	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	20,032	1,002	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	24,561	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	16,997	850	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	65,896	3,295	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	7,509	375	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	33,047	1,652	0	0	0	11.00
200.00			143,481	7,174	24,561	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	20,032	5,559	5,559		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,239,116		2.00
3.00	40.00	SUBPROVIDER - IPF	0	16,997	7,003	7,003		3.00
4.00	40.00	SUBPROVIDER - IPF	0	65,896	171,286	171,286		4.00
5.00	50.00	OPERATING ROOM	0	0	0	14,850		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	270,433		6.00
7.00	60.00	LABORATORY	0	7,509	3,491	3,491		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	48,087		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	64,993		9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	28,709		10.00
11.00	91.00	EMERGENCY	0	33,047	6,953	2,144,888		11.00
200.00			0	143,481	194,292	4,998,415		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/27/2019 11:55 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,364,849	2,364,849			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,683,499		1,683,499		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,912,094	31,902	4,293	7,948,289	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,722,818	258,759	357,686	1,231,154	5.00
7.00	00700	OPERATION OF PLANT	1,310,230	51,744	9,828	158,564	1,530,366
8.00	00800	LAUNDRY & LINEN SERVICE	145,255	3,744	6,462	16,026	171,487
9.00	00900	HOUSEKEEPING	624,490	9,360	1,178	181,535	816,563
10.00	01000	DIETARY	774,401	45,833	7,557	188,620	1,016,411
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	116,491	10,404	207	36,838	163,940
14.00	01400	CENTRAL SERVICES & SUPPLY	431,128	101,025	17,358	89,464	638,975
15.00	01500	PHARMACY	635,948	16,473	35,646	200,485	888,552
16.00	01600	MEDICAL RECORDS & LIBRARY	815,201	12,985	1,691	157,582	987,459
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,392,451	185,379	117,863	967,393	4,663,086
40.00	04000	SUBPROVIDER - IPF	3,450,831	285,121	12,349	807,553	4,555,854
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,128,311	137,478	215,484	220,678	1,701,951
53.00	05300	ANESTHESIOLOGY	47,673	0	15,474	0	63,147
54.00	05400	RADIOLOGY-DIAGNOSTIC	705,506	42,837	132,996	169,832	1,051,171
54.01	05401	ULTRASOUND	233,495	9,833	57,015	68,637	368,980
54.02	03440	MAMMOGRAPHY	128,479	6,069	31,059	21,496	187,103
56.00	05600	RADIOISOTOPE	440,966	36,808	58,787	53,865	590,426
57.00	05700	CT SCAN	327,946	10,365	114,798	61,668	514,777
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	124,322	0	110	9,230	133,662
60.00	06000	LABORATORY	2,276,895	56,631	111,839	286,651	2,732,016
64.00	06400	INTRAVENOUS THERAPY	275	0	0	0	275
65.00	06500	RESPIRATORY THERAPY	723,382	26,108	17,004	207,662	974,156
66.00	06600	PHYSICAL THERAPY	655,741	65,872	7,952	212,219	941,784
67.00	06700	OCCUPATIONAL THERAPY	173,222	3,783	317	55,742	233,064
68.00	06800	SPEECH PATHOLOGY	31,936	0	0	10,515	42,451
69.00	06900	ELECTROCARDIOLOGY	146,385	32,394	2,865	31,193	212,837
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	145,194	0	0	0	145,194
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,497,602	0	0	0	1,497,602
73.00	07300	DRUGS CHARGED TO PATIENTS	1,315,687	0	0	0	1,315,687
75.00	07500	ASC (NON-DISTINCT PART)	754,619	108,473	76,119	207,899	1,147,110
76.00	03950	FAITH CENTER CHEMOTHERAPY	136,739	22,010	10,910	42,917	212,576
76.97	07697	CARDIAC REHABILITATION	106,590	0	1,282	33,967	141,839
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,779,221	230,522	18,588	447,861	2,476,192
88.01	08801	RURAL HEALTH CLINIC II	26,021	0	554	6,300	32,875
88.02	08802	RURAL HEALTH CLINIC III	247,715	17,695	5,799	62,229	333,438
88.03	08803	RURAL HEALTH CLINIC IV	1,672,969	128,847	40,523	380,964	2,223,303
88.04	08804	RURAL HEALTH CLINIC V	1,667,794	189,892	20,086	328,907	2,206,679
91.00	09100	EMERGENCY	1,317,866	128,828	52,384	387,529	1,886,607
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	279,855	0	6,129	80,612	366,596
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,472,092	2,267,174	1,570,192	7,423,787	48,736,608
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,692,785	79,330	113,307	495,905	2,381,327
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0
194.01	07951	AUXILIARY	41,915	13,616	0	13,708	69,239
194.02	07952	FOUNDATION	155,281	4,729	0	14,889	174,899
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	51,362,073	2,364,849	1,683,499	7,948,289	51,362,073

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/27/2019 11:55 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	9,570,417					5.00
7.00	00700	OPERATION OF PLANT	350,458	1,880,824				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	39,271	3,482	214,240			8.00
9.00	00900	HOUSEKEEPING	186,995	8,704	0	1,012,262		9.00
10.00	01000	DIETARY	232,761	42,623	0	0	1,291,795	10.00
11.00	01100	CAFETERIA	0	0	0	0	292,005	11.00
13.00	01300	NURSING ADMINISTRATION	37,543	9,675	0	22,450	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	146,327	93,950	0	0	0	14.00
15.00	01500	PHARMACY	203,481	15,319	0	11,225	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	226,131	12,076	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,067,866	172,398	57,440	290,650	414,530	30.00
40.00	04000	SUBPROVIDER - IPF	1,043,304	265,159	21,587	130,692	349,923	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	389,752	127,851	20,082	56,526	0	50.00
53.00	05300	ANESTHESIOLOGY	14,461	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,721	39,838	14,103	0	0	54.00
54.01	05401	ULTRASOUND	84,498	9,144	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	42,847	5,644	0	0	0	54.02
56.00	05600	RADIOISOTOPE	135,209	34,230	0	0	0	56.00
57.00	05700	CT SCAN	117,885	9,639	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	30,609	0	0	0	0	58.00
60.00	06000	LABORATORY	625,640	52,665	0	22,049	0	60.00
64.00	06400	INTRAVENOUS THERAPY	63	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	223,085	24,280	7,134	21,247	0	65.00
66.00	06600	PHYSICAL THERAPY	215,671	61,259	6,132	18,441	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,372	3,518	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,721	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	48,740	30,126	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,250	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	342,955	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,296	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	262,692	100,877	26,865	80,179	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	48,681	20,469	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	32,482	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	567,055	214,380	20,041	70,959	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,528	0	0	4,811	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	76,358	16,456	4,445	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	509,143	119,825	16,886	60,936	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	505,336	176,595	6,577	32,072	0	88.04
91.00	09100	EMERGENCY	432,039	119,807	12,948	180,403	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	83,952	0	0	9,622	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,969,178	1,789,989	214,240	1,012,262	1,056,458	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	545,331	73,775	0	0	235,337	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	15,856	12,662	0	0	0	194.01
194.02	07952	FOUNDATION	40,052	4,398	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,570,417	1,880,824	214,240	1,012,262	1,291,795	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/27/2019 11:55 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	292,005					11.00
13.00	01300	NURSING ADMINISTRATION	2,035	235,643				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,127	0	889,379			14.00
15.00	01500	PHARMACY	5,640	0	0	1,124,217		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,181	0	3,461	0	1,240,308	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	59,825	70,416	242,630	0	86,914	30.00
40.00	04000	SUBPROVIDER - IPF	52,305	61,566	38,350	0	112,492	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,964	24,676	153,623	0	36,096	50.00
53.00	05300	ANESTHESIOLOGY	0	0	12,448	0	36,508	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,419	0	2,791	0	46,845	54.00
54.01	05401	ULTRASOUND	5,018	0	5,220	0	41,321	54.01
54.02	03440	MAMMOGRAPHY	1,194	0	809	0	4,937	54.02
56.00	05600	RADIOISOTOPE	3,798	0	4,734	0	32,403	56.00
57.00	05700	CT SCAN	3,862	0	7,554	0	155,938	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	5,619	58.00
60.00	06000	LABORATORY	19,846	0	23,529	0	172,914	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	9,495	64.00
65.00	06500	RESPIRATORY THERAPY	11,803	0	18,796	0	59,818	65.00
66.00	06600	PHYSICAL THERAPY	9,304	0	1,997	0	27,107	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,386	0	0	0	9,935	67.00
68.00	06800	SPEECH PATHOLOGY	306	0	368	0	763	68.00
69.00	06900	ELECTROCARDIOLOGY	1,848	0	3,309	0	21,180	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	16,591	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,292	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	884,166	83,155	73.00
75.00	07500	ASC (NON-DISTINCT PART)	16,532	19,459	109,782	0	46,776	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,813	2,133	15,331	0	4,228	76.00
76.97	07697	CARDIAC REHABILITATION	1,652	1,945	3,183	0	7,177	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	18,140	16,070	59,552	25,835	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	235	49	384	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	2,671	13,434	3,992	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	15,863	77,446	26,572	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	16,113	59,052	26,870	88.04
91.00	09100	EMERGENCY	25,524	30,043	177,800	0	118,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	6,172	7,265	4,342	0	4,572	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	284,554	235,643	881,009	1,093,699	1,240,308	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,309	0	6,997	30,518	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	1,301	0	223	0	0	194.01
194.02	07952	FOUNDATION	1,841	0	1,150	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	292,005	235,643	889,379	1,124,217	1,240,308	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/27/2019 11:55 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	7,125,755	-350,198	6,775,557	30.00
40.00	04000	SUBPROVIDER - IPF	0	6,631,232	0	6,631,232	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,531,521	0	2,531,521	50.00
53.00	05300	ANESTHESIOLOGY	0	126,564	0	126,564	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,406,888	0	1,406,888	54.00
54.01	05401	ULTRASOUND	0	514,181	0	514,181	54.01
54.02	03440	MAMMOGRAPHY	0	242,534	0	242,534	54.02
56.00	05600	RADIOISOTOPE	0	800,800	0	800,800	56.00
57.00	05700	CT SCAN	0	809,655	0	809,655	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	169,890	0	169,890	58.00
60.00	06000	LABORATORY	0	3,648,659	0	3,648,659	60.00
64.00	06400	INTRAVENOUS THERAPY	0	9,833	350,198	360,031	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,340,319	0	1,340,319	65.00
66.00	06600	PHYSICAL THERAPY	0	1,281,695	0	1,281,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	302,275	0	302,275	67.00
68.00	06800	SPEECH PATHOLOGY	0	53,609	0	53,609	68.00
69.00	06900	ELECTROCARDIOLOGY	0	318,040	0	318,040	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	195,035	0	195,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,855,849	0	1,855,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,584,304	0	2,584,304	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,810,272	0	1,810,272	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	305,231	0	305,231	76.00
76.97	07697	CARDIAC REHABILITATION	0	188,278	0	188,278	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,468,224	0	3,468,224	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	45,882	0	45,882	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	450,794	0	450,794	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	3,049,974	0	3,049,974	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	3,029,294	0	3,029,294	88.04
91.00	09100	EMERGENCY	0	2,983,750	0	2,983,750	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	482,521	0	482,521	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	47,762,858	0	47,762,858	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,277,594	0	3,277,594	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	99,281	0	99,281	194.01
194.02	07952	FOUNDATION	0	222,340	0	222,340	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	51,362,073	0	51,362,073	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/27/2019 11:55 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	31,902	4,293	36,195	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,900	258,759	357,686	626,345	5.00
7.00	00700	OPERATION OF PLANT	9,592	51,744	9,828	71,164	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,744	6,462	10,206	8.00
9.00	00900	HOUSEKEEPING	0	9,360	1,178	10,538	9.00
10.00	01000	DIETARY	0	45,833	7,557	53,390	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,404	207	10,611	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,951	101,025	17,358	121,334	14.00
15.00	01500	PHARMACY	0	16,473	35,646	52,119	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,985	1,691	14,676	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,449	185,379	117,863	309,691	30.00
40.00	04000	SUBPROVIDER - IPF	0	285,121	12,349	297,470	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	182,612	137,478	215,484	535,574	50.00
53.00	05300	ANESTHESIOLOGY	8,412	0	15,474	23,886	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,837	132,996	175,833	54.00
54.01	05401	ULTRASOUND	0	9,833	57,015	66,848	54.01
54.02	03440	MAMMOGRAPHY	0	6,069	31,059	37,128	54.02
56.00	05600	RADIOISOTOPE	0	36,808	58,787	95,595	56.00
57.00	05700	CT SCAN	0	10,365	114,798	125,163	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	93,350	0	110	93,460	58.00
60.00	06000	LABORATORY	0	56,631	111,839	168,470	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	26,951	26,108	17,004	70,063	65.00
66.00	06600	PHYSICAL THERAPY	900	65,872	7,952	74,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,783	317	4,100	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	47,055	32,394	2,865	82,314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	108,473	76,119	184,592	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	22,010	10,910	32,920	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	1,282	1,282	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,651	230,522	18,588	250,761	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,680	0	554	4,234	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	17,695	5,799	23,494	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	128,847	40,523	169,370	88.03
88.04	08804	RURAL HEALTH CLINIC V	4,500	189,892	20,086	214,478	88.04
91.00	09100	EMERGENCY	0	128,828	52,384	181,212	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	0	6,129	6,129	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398,003	2,267,174	1,570,192	4,235,369	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,873	79,330	113,307	202,510	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	13,616	0	13,616	194.01
194.02	07952	FOUNDATION	0	4,729	0	4,729	194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	407,876	2,364,849	1,683,499	4,456,224	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/27/2019 11:55 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	631,946					5.00
7.00	00700	OPERATION OF PLANT	23,141	95,027				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,593	176	13,048			8.00
9.00	00900	HOUSEKEEPING	12,347	440	0	24,152		9.00
10.00	01000	DIETARY	15,369	2,153	0	0	71,771	10.00
11.00	01100	CAFETERIA	0	0	0	0	16,224	11.00
13.00	01300	NURSING ADMINISTRATION	2,479	489	0	536	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,662	4,747	0	0	0	14.00
15.00	01500	PHARMACY	13,436	774	0	268	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,931	610	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,527	8,710	3,498	6,934	23,031	30.00
40.00	04000	SUBPROVIDER - IPF	68,889	13,398	1,315	3,118	19,441	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,735	6,460	1,223	1,349	0	50.00
53.00	05300	ANESTHESIOLOGY	955	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,895	2,013	859	0	0	54.00
54.01	05401	ULTRASOUND	5,579	462	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	2,829	285	0	0	0	54.02
56.00	05600	RADIOISOTOPE	8,928	1,729	0	0	0	56.00
57.00	05700	CT SCAN	7,784	487	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,021	0	0	0	0	58.00
60.00	06000	LABORATORY	41,311	2,661	0	526	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	14,730	1,227	434	507	0	65.00
66.00	06600	PHYSICAL THERAPY	14,241	3,095	373	440	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,524	178	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	642	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,218	1,522	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,195	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,645	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,895	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	17,345	5,097	1,636	1,913	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3,214	1,034	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,145	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	37,442	10,831	1,221	1,693	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	497	0	0	115	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,042	831	271	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	33,619	6,054	1,028	1,454	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	33,367	8,922	401	765	0	88.04
91.00	09100	EMERGENCY	28,527	6,053	789	4,304	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	5,543	0	0	230	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	592,246	90,438	13,048	24,152	58,696	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	36,008	3,727	0	0	13,075	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	1,047	640	0	0	0	194.01
194.02	07952	FOUNDATION	2,645	222	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	631,946	95,027	13,048	24,152	71,771	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/27/2019 11:55 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	16,224					11.00
13.00	01300	NURSING ADMINISTRATION	113	14,396				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	563	0	136,713			14.00
15.00	01500	PHARMACY	313	0	0	67,823		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	621	0	532	0	32,088	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,323	4,303	37,297	0	2,247	30.00
40.00	04000	SUBPROVIDER - IPF	2,906	3,761	5,895	0	2,908	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,165	1,507	23,614	0	933	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,914	0	944	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	634	0	429	0	1,211	54.00
54.01	05401	ULTRASOUND	279	0	802	0	1,068	54.01
54.02	03440	MAMMOGRAPHY	66	0	124	0	128	54.02
56.00	05600	RADIOISOTOPE	211	0	728	0	838	56.00
57.00	05700	CT SCAN	215	0	1,161	0	4,031	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	145	58.00
60.00	06000	LABORATORY	1,103	0	3,617	0	4,493	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	245	64.00
65.00	06500	RESPIRATORY THERAPY	656	0	2,889	0	1,546	65.00
66.00	06600	PHYSICAL THERAPY	517	0	307	0	701	66.00
67.00	06700	OCCUPATIONAL THERAPY	133	0	0	0	257	67.00
68.00	06800	SPEECH PATHOLOGY	17	0	57	0	20	68.00
69.00	06900	ELECTROCARDIOLOGY	103	0	509	0	548	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	395	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	53,341	2,150	73.00
75.00	07500	ASC (NON-DISTINCT PART)	919	1,189	16,875	0	1,209	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	101	130	2,357	0	109	76.00
76.97	07697	CARDIAC REHABILITATION	92	119	489	0	186	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,108	2,470	3,593	668	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	36	3	10	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	411	810	103	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	2,438	4,672	687	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	2,477	3,563	695	88.04
91.00	09100	EMERGENCY	1,418	1,835	27,331	0	3,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	343	444	667	0	118	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,811	14,396	135,426	65,982	32,088	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	239	0	1,076	1,841	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	72	0	34	0	0	194.01
194.02	07952	FOUNDATION	102	0	177	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,224	14,396	136,713	67,823	32,088	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		473,967	0	473,967	30.00
40.00	04000	SUBPROVIDER - IPF		422,779	0	422,779	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		598,565	0	598,565	50.00
53.00	05300	ANESTHESIOLOGY		27,699	0	27,699	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		197,647	0	197,647	54.00
54.01	05401	ULTRASOUND		75,351	0	75,351	54.01
54.02	03440	MAMMOGRAPHY		40,658	0	40,658	54.02
56.00	05600	RADIOISOTOPE		108,274	0	108,274	56.00
57.00	05700	CT SCAN		139,122	0	139,122	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		95,668	0	95,668	58.00
60.00	06000	LABORATORY		223,487	0	223,487	60.00
64.00	06400	INTRAVENOUS THERAPY		249	0	249	64.00
65.00	06500	RESPIRATORY THERAPY		92,998	0	92,998	65.00
66.00	06600	PHYSICAL THERAPY		95,365	0	95,365	66.00
67.00	06700	OCCUPATIONAL THERAPY		8,446	0	8,446	67.00
68.00	06800	SPEECH PATHOLOGY		784	0	784	68.00
69.00	06900	ELECTROCARDIOLOGY		88,356	0	88,356	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		2,624	0	2,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		23,040	0	23,040	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		75,386	0	75,386	73.00
75.00	07500	ASC (NON-DISTINCT PART)		231,722	0	231,722	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		40,060	0	40,060	76.00
76.97	07697	CARDIAC REHABILITATION		4,468	0	4,468	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		311,827	0	311,827	88.00
88.01	08801	RURAL HEALTH CLINIC II		4,924	0	4,924	88.01
88.02	08802	RURAL HEALTH CLINIC III		31,245	0	31,245	88.02
88.03	08803	RURAL HEALTH CLINIC IV		221,057	0	221,057	88.03
88.04	08804	RURAL HEALTH CLINIC V		266,166	0	266,166	88.04
91.00	09100	EMERGENCY		256,300	0	256,300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		13,841	0	13,841	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,172,075	0	4,172,075	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES		260,735	0	260,735	192.00
194.00	07950	RETAIL 340B PHARMACY		0	0	0	194.00
194.01	07951	AUXILIARY		15,471	0	15,471	194.01
194.02	07952	FOUNDATION		7,943	0	7,943	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,456,224	0	4,456,224	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0210

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

Worksheet B-1

Date/Time Prepared:
11/27/2019 11:55 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	120,016					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,631,770				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,619	4,161	23,894,216			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,132	346,691	3,701,121	-9,570,417	41,791,656	5.00
7.00	00700	OPERATION OF PLANT	2,626	9,526	476,677	0	1,530,366	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	6,263	48,177	0	171,487	8.00
9.00	00900	HOUSEKEEPING	475	1,142	545,732	0	816,563	9.00
10.00	01000	DIETARY	2,326	7,325	567,030	0	1,016,411	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	528	201	110,742	0	163,940	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,127	16,825	268,946	0	638,975	14.00
15.00	01500	PHARMACY	836	34,551	602,699	0	888,552	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	659	1,639	473,725	0	987,459	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,408	114,241	2,908,184	0	4,663,086	30.00
40.00	04000	SUBPROVIDER - IPF	14,470	11,970	2,427,672	0	4,555,854	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,977	208,863	663,403	0	1,701,951	50.00
53.00	05300	ANESTHESIOLOGY	0	14,999	0	0	63,147	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,174	128,909	510,551	0	1,051,171	54.00
54.01	05401	ULTRASOUND	499	55,263	206,338	0	368,980	54.01
54.02	03440	MAMMOGRAPHY	308	30,105	64,622	0	187,103	54.02
56.00	05600	RADIOISOTOPE	1,868	56,981	161,928	0	590,426	56.00
57.00	05700	CT SCAN	526	111,271	185,386	0	514,777	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	107	27,747	0	133,662	58.00
60.00	06000	LABORATORY	2,874	108,403	861,732	0	2,732,016	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	275	64.00
65.00	06500	RESPIRATORY THERAPY	1,325	16,482	624,276	0	974,156	65.00
66.00	06600	PHYSICAL THERAPY	3,343	7,708	637,974	0	941,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	307	167,571	0	233,064	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	31,610	0	42,451	68.00
69.00	06900	ELECTROCARDIOLOGY	1,644	2,777	93,773	0	212,837	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	145,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,497,602	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,315,687	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,505	73,780	624,988	0	1,147,110	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,117	10,575	129,016	0	212,576	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,243	102,112	0	141,839	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	11,699	18,017	1,346,363	0	2,476,192	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	537	18,939	0	32,875	88.01
88.02	08802	RURAL HEALTH CLINIC III	898	5,621	187,072	0	333,438	88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,539	39,278	1,145,256	0	2,223,303	88.03
88.04	08804	RURAL HEALTH CLINIC V	9,637	19,469	988,763	0	2,206,679	88.04
91.00	09100	EMERGENCY	6,538	50,774	1,164,992	0	1,886,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	5,941	242,336	0	366,596	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,059	1,521,945	22,317,453	-9,570,417	39,166,191	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,026	109,825	1,490,794	0	2,381,327	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	691	0	41,209	0	69,239	194.01
194.02	07952	FOUNDATION	240	0	44,760	0	174,899	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,364,849	1,683,499	7,948,289		9,570,417	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.704448	1.031701	0.332645		0.229003	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			36,195		631,946	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001515		0.015121	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0210

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

Worksheet B-1

Date/Time Prepared:
11/27/2019 11:55 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	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0210

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

Worksheet B-1

Date/Time Prepared:
11/27/2019 11:55 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	
		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	102,639				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	190	51,955			8.00
9.00	00900	HOUSEKEEPING	475	0	2,525		9.00
10.00	01000	DIETARY	2,326	0	0	226,361	10.00
11.00	01100	CAFETERIA	0	0	0	51,168	11.00
13.00	01300	NURSING ADMINISTRATION	528	0	56	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,127	0	0	0	14.00
15.00	01500	PHARMACY	836	0	28	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	659	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,408	13,930	725	72,638	30.00
40.00	04000	SUBPROVIDER - IPF	14,470	5,235	326	61,317	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,977	4,870	141	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,174	3,420	0	0	54.00
54.01	05401	ULTRASOUND	499	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	308	0	0	0	54.02
56.00	05600	RADIOISOTOPE	1,868	0	0	0	56.00
57.00	05700	CT SCAN	526	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	2,874	0	55	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,325	1,730	53	0	65.00
66.00	06600	PHYSICAL THERAPY	3,343	1,487	46	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	192	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,644	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,505	6,515	200	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	1,117	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	11,699	4,860	177	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	12	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	898	1,078	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,539	4,095	152	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	9,637	1,595	80	0	88.04
91.00	09100	EMERGENCY	6,538	3,140	450	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				56,298	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	24	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	97,682	51,955	2,525	185,123	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,026	0	0	41,238	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	194.00
194.01	07951	AUXILIARY	691	0	0	0	194.01
194.02	07952	FOUNDATION	240	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,880,824	214,240	1,012,262	1,291,795	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.324652	4.123568	400.895842	5.706791	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	95,027	13,048	24,152	71,771	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.925837	0.251140	9.565149	0.317064	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: 14-0210

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

Worksheet B-1

Date/Time Prepared:

11/27/2019 11:55 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	441,577					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	665,298				14.00
15.00	01500	PHARMACY	0	0	1,672,897			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,589	0	138,214,016		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	131,956	181,500	0	9,685,086	0	30.00
40.00	04000	SUBPROVIDER - IPF	115,369	28,688	0	12,535,369	0	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	46,240	114,917	0	4,022,312	0	50.00
53.00	05300	ANESTHESIOLOGY	0	9,312	0	4,068,187	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,088	0	5,220,029	0	54.00
54.01	05401	ULTRASOUND	0	3,905	0	4,604,544	0	54.01
54.02	03440	MAMMOGRAPHY	0	605	0	550,140	0	54.02
56.00	05600	RADIOISOTOPE	0	3,541	0	3,610,727	0	56.00
57.00	05700	CT SCAN	0	5,651	0	17,376,657	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	626,150	0	58.00
60.00	06000	LABORATORY	0	17,601	0	19,270,861	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,058,100	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,060	0	6,665,708	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,494	0	3,020,599	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,107,141	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	275	0	84,997	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,475	0	2,360,176	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,848,781	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,704,087	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,315,687	9,266,218	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	36,465	82,122	0	5,212,428	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	3,998	11,468	0	471,098	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,644	2,381	0	799,778	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	33,993	12,021	88,617	2,878,913	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	176	73	42,762	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	1,998	19,991	444,807	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	11,866	115,244	2,961,013	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	12,053	87,872	2,994,228	0	88.04
91.00	09100	EMERGENCY	56,298	133,003	0	13,213,656	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	13,614	3,248	0	509,464	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	441,577	659,037	1,627,484	138,214,016	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,234	45,413	0	0	192.00
194.00	07950	RETAIL 340B PHARMACY	0	0	0	0	0	194.00
194.01	07951	AUXILIARY	0	167	0	0	0	194.01
194.02	07952	FOUNDATION	0	860	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	235,643	889,379	1,124,217	1,240,308	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.533640	1.336813	0.672018	0.008974	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,396	136,713	67,823	32,088	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.032601	0.205491	0.040542	0.000232	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 14-0210

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

Worksheet B-2

Date/Time Prepared:
11/27/2019 11:55 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		IV THERAPY		1	30.00	- 350,198 7.00
8.00		IV THERAPY		1	64.00	350,198 8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/27/2019 11:55 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	6,775,557		6,775,557	0	6,775,557	30.00
40.00	04000	SUBPROVIDER - IPF	6,631,232		6,631,232	178,289	6,809,521	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,531,521		2,531,521	0	2,531,521	50.00
53.00	05300	ANESTHESIOLOGY	126,564		126,564	0	126,564	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,406,888		1,406,888	0	1,406,888	54.00
54.01	05401	ULTRASOUND	514,181		514,181	0	514,181	54.01
54.02	03440	MAMMOGRAPHY	242,534		242,534	0	242,534	54.02
56.00	05600	RADIOISOTOPE	800,800		800,800	0	800,800	56.00
57.00	05700	CT SCAN	809,655		809,655	0	809,655	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	169,890		169,890	0	169,890	58.00
60.00	06000	LABORATORY	3,648,659		3,648,659	3,491	3,652,150	60.00
64.00	06400	INTRAVENOUS THERAPY	360,031		360,031	0	360,031	64.00
65.00	06500	RESPIRATORY THERAPY	1,340,319	0	1,340,319	0	1,340,319	65.00
66.00	06600	PHYSICAL THERAPY	1,281,695	0	1,281,695	0	1,281,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	302,275	0	302,275	0	302,275	67.00
68.00	06800	SPEECH PATHOLOGY	53,609	0	53,609	0	53,609	68.00
69.00	06900	ELECTROCARDIOLOGY	318,040		318,040	0	318,040	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	195,035		195,035	0	195,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,855,849		1,855,849	0	1,855,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,584,304		2,584,304	0	2,584,304	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,810,272		1,810,272	0	1,810,272	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	305,231		305,231	0	305,231	76.00
76.97	07697	CARDIAC REHABILITATION	188,278		188,278	0	188,278	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,468,224		3,468,224	0	3,468,224	88.00
88.01	08801	RURAL HEALTH CLINIC II	45,882		45,882	0	45,882	88.01
88.02	08802	RURAL HEALTH CLINIC III	450,794		450,794	0	450,794	88.02
88.03	08803	RURAL HEALTH CLINIC IV	3,049,974		3,049,974	0	3,049,974	88.03
88.04	08804	RURAL HEALTH CLINIC V	3,029,294		3,029,294	0	3,029,294	88.04
91.00	09100	EMERGENCY	2,983,750		2,983,750	6,953	2,990,703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,563,698		1,563,698	0	1,563,698	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	482,521		482,521	0	482,521	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	49,326,556	0	49,326,556	188,733	49,515,289	200.00
201.00		Less Observation Beds	1,563,698		1,563,698		1,563,698	201.00
202.00		Total (see instructions)	47,762,858	0	47,762,858	188,733	47,951,591	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/27/2019 11:55 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	5,430,396		5,430,396			30.00	
40.00	04000	SUBPROVIDER - IPF	12,535,369		12,535,369			40.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	978,373	3,043,939	4,022,312	0.629370	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	846,738	3,221,449	4,068,187	0.031111	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	471,887	4,748,142	5,220,029	0.269517	0.000000	54.00	
54.01	05401	ULTRASOUND	902,016	3,702,528	4,604,544	0.111668	0.000000	54.01	
54.02	03440	MAMMOGRAPHY	0	550,140	550,140	0.440859	0.000000	54.02	
56.00	05600	RADIOISOTOPE	304,856	3,305,871	3,610,727	0.221784	0.000000	56.00	
57.00	05700	CT SCAN	1,788,944	15,587,713	17,376,657	0.046594	0.000000	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	41,225	584,925	626,150	0.271325	0.000000	58.00	
60.00	06000	LABORATORY	3,266,709	16,004,152	19,270,861	0.189336	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	271,906	786,194	1,058,100	0.340262	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	4,037,188	2,628,520	6,665,708	0.201077	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	657,189	2,363,410	3,020,599	0.424318	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	421,734	685,407	1,107,141	0.273023	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	26,470	58,527	84,997	0.630716	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	397,794	1,962,382	2,360,176	0.134753	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	843,184	1,005,597	1,848,781	0.105494	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	969,846	734,241	1,704,087	1.089058	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,331,617	5,934,601	9,266,218	0.278895	0.000000	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	119,753	5,092,675	5,212,428	0.347299	0.000000	75.00	
76.00	03950	FAITH CENTER CHEMOTHERAPY	198	470,900	471,098	0.647914	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	1,250	798,528	799,778	0.235413	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,878,913	2,878,913			88.00	
88.01	08801	RURAL HEALTH CLINIC II	0	42,762	42,762			88.01	
88.02	08802	RURAL HEALTH CLINIC III	0	444,807	444,807			88.02	
88.03	08803	RURAL HEALTH CLINIC IV	0	2,961,013	2,961,013			88.03	
88.04	08804	RURAL HEALTH CLINIC V	0	2,994,228	2,994,228			88.04	
91.00	09100	EMERGENCY	1,603,751	11,609,905	13,213,656	0.225808	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,054,625	3,200,065	4,254,690	0.367523	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	509,464	509,464			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	40,303,018	97,910,998	138,214,016			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	40,303,018	97,910,998	138,214,016			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/27/2019 11:55 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
40.00	04000	SUBPROVIDER - IPF			40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.629370		50.00
53.00	05300	ANESTHESIOLOGY	0.031111		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269517		54.00
54.01	05401	ULTRASOUND	0.111668		54.01
54.02	03440	MAMMOGRAPHY	0.440859		54.02
56.00	05600	RADIOISOTOPE	0.221784		56.00
57.00	05700	CT SCAN	0.046594		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.271325		58.00
60.00	06000	LABORATORY	0.189517		60.00
64.00	06400	INTRAVENOUS THERAPY	0.340262		64.00
65.00	06500	RESPIRATORY THERAPY	0.201077		65.00
66.00	06600	PHYSICAL THERAPY	0.424318		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273023		67.00
68.00	06800	SPEECH PATHOLOGY	0.630716		68.00
69.00	06900	ELECTROCARDIOLOGY	0.134753		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105494		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.089058		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278895		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.347299		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.647914		76.00
76.97	07697	CARDIAC REHABILITATION	0.235413		76.97
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	08804	RURAL HEALTH CLINIC V			88.04
91.00	09100	EMERGENCY	0.226334		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.367523		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/27/2019 11:55 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS 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		473,967	2,472	471,495	6,082	77.52	30.00
40.00	SUBPROVIDER - IPF		422,779	0	422,779	9,274	45.59	40.00
200.00	Total (lines 30 through 199)		896,746		894,274	15,356		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		2,962	229,614				
40.00	SUBPROVIDER - IPF		2,910	132,667				
200.00	Total (lines 30 through 199)		5,872	362,281				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/27/2019 11:55 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	598,565	4,022,312	0.148811	528,501	78,647	50.00
53.00	05300	ANESTHESIOLOGY	27,699	4,068,187	0.006809	473,360	3,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,647	5,220,029	0.037863	449,458	17,018	54.00
54.01	05401	ULTRASOUND	75,351	4,604,544	0.016364	777,031	12,715	54.01
54.02	03440	MAMMOGRAPHY	40,658	550,140	0.073905	0	0	54.02
56.00	05600	RADIOISOTOPE	108,274	3,610,727	0.029987	240,591	7,215	56.00
57.00	05700	CT SCAN	139,122	17,376,657	0.008006	1,719,337	13,765	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	95,668	626,150	0.152788	19,977	3,052	58.00
60.00	06000	LABORATORY	223,487	19,270,861	0.011597	2,965,580	34,392	60.00
64.00	06400	INTRAVENOUS THERAPY	249	1,058,100	0.000235	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	92,998	6,665,708	0.013952	2,868,637	40,023	65.00
66.00	06600	PHYSICAL THERAPY	95,365	3,020,599	0.031572	402,409	12,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,446	1,107,141	0.007629	280,768	2,142	67.00
68.00	06800	SPEECH PATHOLOGY	784	84,997	0.009224	19,315	178	68.00
69.00	06900	ELECTROCARDIOLOGY	88,356	2,360,176	0.037436	371,037	13,890	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,624	1,848,781	0.001419	588,310	835	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,040	1,704,087	0.013520	545,279	7,372	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,386	9,266,218	0.008136	1,462,839	11,902	73.00
75.00	07500	ASC (NON-DISTINCT PART)	231,722	5,212,428	0.044456	92,766	4,124	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	40,060	471,098	0.085035	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,468	799,778	0.005587	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	311,827	2,878,913	0.108314	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,924	42,762	0.115149	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	31,245	444,807	0.070244	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	221,057	2,961,013	0.074656	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	266,166	2,994,228	0.088893	0	0	88.04
91.00	09100	EMERGENCY	256,300	13,213,656	0.019397	1,432,480	27,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	109,384	4,254,690	0.025709	515,168	13,244	92.00
200.00		Total (lines 50 through 199)	3,370,872	119,738,787		15,752,843	304,228	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/27/2019 11:55 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	0	30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	6,082	0.00	2,962			30.00	
40.00	04000	SUBPROVIDER - IPF	0	0	9,274	0.00	2,910			40.00	
200.00		Total (lines 30 through 199)		0	15,356		5,872			200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/27/2019 11:55 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
56.00	05600	RADIOTISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	08804	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: 14-0210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/27/2019 11:55 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	4,022,312	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	4,068,187	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	5,220,029	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	4,604,544	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	550,140	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	3,610,727	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	17,376,657	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	626,150	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	0	19,270,861	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	1,058,100	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	6,665,708	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	3,020,599	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,107,141	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	84,997	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	2,360,176	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,848,781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,704,087	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,266,218	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	5,212,428	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	471,098	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	799,778	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,878,913	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	42,762	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	444,807	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	2,961,013	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	2,994,228	0.000000	88.04
91.00	09100	EMERGENCY	0	0	0	0	13,213,656	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	4,254,690	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	119,738,787		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/27/2019 11:55 am	
Cost Center Description				Title XVIII		Hospital		PPS	
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		528,501	0	931,665	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000		473,360	0	1,054,383	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		449,458	0	1,325,783	0	54.00
54.01	05401	ULTRASOUND	0.000000		777,031	0	1,326,433	0	54.01
54.02	03440	MAMMOGRAPHY	0.000000		0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.000000		240,591	0	1,476,977	0	56.00
57.00	05700	CT SCAN	0.000000		1,719,337	0	5,082,733	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		19,977	0	0	0	58.00
60.00	06000	LABORATORY	0.000000		2,965,580	0	2,868,550	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		2,868,637	0	771,204	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		402,409	0	15,984	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		280,768	0	9,814	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		19,315	0	328	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		371,037	0	740,104	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		588,310	0	291,998	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		545,279	0	298,558	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		1,462,839	0	2,949,960	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		92,766	0	2,023,886	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.000000		0	0	37,568	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	338,779	0	76.97
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	08804	RURAL HEALTH CLINIC V	0.000000		0	0	0	0	88.04
91.00	09100	EMERGENCY	0.000000		1,432,480	0	3,453,110	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		515,168	0	807,703	0	92.00
200.00		Total (lines 50 through 199)			15,752,843	0	25,805,520	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST					Provider CCN: 14-0210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/27/2019 11:55 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	0.629370	931,665	0	0	586,362	50.00		
53.00	05300	ANESTHESIOLOGY	0.031111	1,054,383	0	0	32,803	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269517	1,325,783	0	0	357,321	54.00		
54.01	05401	ULTRASOUND	0.111668	1,326,433	0	0	148,120	54.01		
54.02	03440	MAMMOGRAPHY	0.440859	0	0	0	0	54.02		
56.00	05600	RADIOISOTOPE	0.221784	1,476,977	0	0	327,570	56.00		
57.00	05700	CT SCAN	0.046594	5,082,733	0	0	236,825	57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.271325	0	0	0	0	58.00		
60.00	06000	LABORATORY	0.189336	2,868,550	0	0	543,120	60.00		
64.00	06400	INTRAVENOUS THERAPY	0.340262	0	0	0	0	64.00		
65.00	06500	RESPIRATORY THERAPY	0.201077	771,204	0	0	155,071	65.00		
66.00	06600	PHYSICAL THERAPY	0.424318	15,984	0	0	6,782	66.00		
67.00	06700	OCCUPATIONAL THERAPY	0.273023	9,814	0	0	2,679	67.00		
68.00	06800	SPEECH PATHOLOGY	0.630716	328	0	0	207	68.00		
69.00	06900	ELECTROCARDIOLOGY	0.134753	740,104	0	0	99,731	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105494	291,998	0	0	30,804	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.089058	298,558	0	0	325,147	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278895	2,949,960	0	3,116	822,729	73.00		
75.00	07500	ASC (NON-DISTINCT PART)	0.347299	2,023,886	0	0	702,894	75.00		
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.647914	37,568	0	0	24,341	76.00		
76.97	07697	CARDIAC REHABILITATION	0.235413	338,779	0	0	79,753	76.97		
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	08804	RURAL HEALTH CLINIC V	0.000000				0	88.04		
91.00	09100	EMERGENCY	0.225808	3,453,110	0	570	779,740	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.367523	807,703	0	0	296,849	92.00		
200.00		Subtotal (see instructions)		25,805,520	0	3,686	5,558,848	200.00		
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00		
202.00		Net Charges (line 200 - line 201)		25,805,520	0	3,686	5,558,848	202.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0210		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part V Date/Time Prepared: 11/27/2019 11:55 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
54.02	03440	MAMMOGRAPHY	0	0		54.02
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	869		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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	08804	RURAL HEALTH CLINIC V	0	0		88.04
91.00	09100	EMERGENCY	0	129		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	998		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	998		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part II Date/Time Prepared: 11/27/2019 11:55 am	
				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	598,565	4,022,312	0.148811	0	0 50.00
53.00	05300	ANESTHESIOLOGY	27,699	4,068,187	0.006809	1,668	11 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	197,647	5,220,029	0.037863	18,696	708 54.00
54.01	05401	ULTRASOUND	75,351	4,604,544	0.016364	9,151	150 54.01
54.02	03440	MAMMOGRAPHY	40,658	550,140	0.073905	0	0 54.02
56.00	05600	RADIOISOTOPE	108,274	3,610,727	0.029987	7,044	211 56.00
57.00	05700	CT SCAN	139,122	17,376,657	0.008006	58,714	470 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	95,668	626,150	0.152788	0	0 58.00
60.00	06000	LABORATORY	223,487	19,270,861	0.011597	281,212	3,261 60.00
64.00	06400	INTRAVENOUS THERAPY	249	1,058,100	0.000235	2,855	1 64.00
65.00	06500	RESPIRATORY THERAPY	92,998	6,665,708	0.013952	220,358	3,074 65.00
66.00	06600	PHYSICAL THERAPY	95,365	3,020,599	0.031572	33,363	1,053 66.00
67.00	06700	OCCUPATIONAL THERAPY	8,446	1,107,141	0.007629	9,172	70 67.00
68.00	06800	SPEECH PATHOLOGY	784	84,997	0.009224	820	8 68.00
69.00	06900	ELECTROCARDIOLOGY	88,356	2,360,176	0.037436	23,010	861 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,624	1,848,781	0.001419	21,599	31 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,040	1,704,087	0.013520	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,386	9,266,218	0.008136	464,995	3,783 73.00
75.00	07500	ASC (NON-DISTINCT PART)	231,722	5,212,428	0.044456	0	0 75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	40,060	471,098	0.085035	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	4,468	799,778	0.005587	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	311,827	2,878,913	0.108314	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	4,924	42,762	0.115149	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	31,245	444,807	0.070244	0	0 88.02
88.03	08803	RURAL HEALTH CLINIC IV	221,057	2,961,013	0.074656	0	0 88.03
88.04	08804	RURAL HEALTH CLINIC V	266,166	2,994,228	0.088893	0	0 88.04
91.00	09100	EMERGENCY	256,300	13,213,656	0.019397	150,526	2,920 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,254,690	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	3,261,488	119,738,787		1,303,183	16,612 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/27/2019 11:55 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	0	0	54.02
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	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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	08804	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: 14-0210 Component CCN: 14-S210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/27/2019 11:55 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	4,022,312	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,068,187	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,220,029	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	4,604,544	0.000000	54.01
54.02	03440	MAMMOGRAPHY	0	0	0	550,140	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	3,610,727	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	17,376,657	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	626,150	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	19,270,861	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,058,100	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,665,708	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,020,599	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,107,141	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	84,997	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,360,176	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,848,781	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,704,087	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,266,218	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	5,212,428	0.000000	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0	0	471,098	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	799,778	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,878,913	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	42,762	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	444,807	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	2,961,013	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	2,994,228	0.000000	88.04
91.00	09100	EMERGENCY	0	0	0	13,213,656	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,254,690	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	119,738,787		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/27/2019 11:55 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	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	1,668	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	18,696	0	290	0	54.00
54.01	05401	ULTRASOUND		0.000000	9,151	0	0	0	54.01
54.02	03440	MAMMOGRAPHY		0.000000	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE		0.000000	7,044	0	0	0	56.00
57.00	05700	CT SCAN		0.000000	58,714	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	281,212	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	2,855	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	220,358	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	33,363	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	9,172	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	820	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	23,010	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	21,599	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	464,995	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
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	08804	RURAL HEALTH CLINIC V		0.000000	0	0	0	0	88.04
91.00	09100	EMERGENCY		0.000000	150,526	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,303,183	0	290	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/27/2019 11:55 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.629370	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.031111	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269517	290	0	0	78	54.00
54.01	05401	ULTRASOUND	0.111668	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.440859	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.221784	0	0	0	0	56.00
57.00	05700	CT SCAN	0.046594	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.271325	0	0	0	0	58.00
60.00	06000	LABORATORY	0.189336	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.340262	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.201077	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.424318	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273023	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.630716	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.134753	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105494	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.089058	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278895	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.347299	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.647914	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.235413	0	0	0	0	76.97
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	08804	RURAL HEALTH CLINIC V	0.000000				0	88.04
91.00	09100	EMERGENCY	0.225808	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.367523	0	0	0	0	92.00
200.00		Subtotal (see instructions)		290	0	0	78	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		290	0	0	78	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/27/2019 11:55 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Costs							
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)						
	6.00	7.00						
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0				50.00
53.00	05300	ANESTHESIOLOGY	0	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0				54.00
54.01	05401	ULTRASOUND	0	0				54.01
54.02	03440	MAMMOGRAPHY	0	0				54.02
56.00	05600	RADIOISOTOPE	0	0				56.00
57.00	05700	CT SCAN	0	0				57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
60.00	06000	LABORATORY	0	0				60.00
64.00	06400	INTRAVENOUS THERAPY	0	0				64.00
65.00	06500	RESPIRATORY THERAPY	0	0				65.00
66.00	06600	PHYSICAL THERAPY	0	0				66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0				67.00
68.00	06800	SPEECH PATHOLOGY	0	0				68.00
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0				75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0				76.00
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0				88.00
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	08804	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	0				200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00		Net Charges (line 200 - line 201)	0	0				202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210

Period:

Worksheet D

Component CCN: 14-U210

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/27/2019 11:55 am

			Title XVIII		Swing Beds - SNF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.629370	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.031111	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269517	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.111668	0	0	0	0	54.01
54.02	03440	MAMMOGRAPHY	0.440859	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0.221784	0	0	0	0	56.00
57.00	05700	CT SCAN	0.046594	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.271325	0	0	0	0	58.00
60.00	06000	LABORATORY	0.189336	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.340262	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.201077	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.424318	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273023	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.630716	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.134753	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105494	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.089058	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278895	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.347299	0	0	0	0	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.647914	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.235413	0	0	0	0	76.97
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	08804	RURAL HEALTH CLINIC V	0.000000				0	88.04
91.00	09100	EMERGENCY	0.225808	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.367523	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0210

Period:

Worksheet D

Component CCN: 14-U210

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/27/2019 11:55 am

			Title XVIII		Swing Beds - SNF		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05401	ULTRASOUND	0	0					54.01
54.02	03440	MAMMOGRAPHY	0	0					54.02
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0	0					64.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0	0					76.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
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	08804	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	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/27/2019 11:55 am
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,242	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,082	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)		4,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		82	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)		63	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		9	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)		6	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,962	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)		82	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)		51	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		224.47	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		231.33	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,775,557	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)		18,407	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)		14,574	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)		1,415	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)		943	25.00
26.00	Total swing-bed cost (see instructions)		35,339	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,740,218	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)		6,740,218	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)		1,108.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,282,548	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,282,548	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210

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

Worksheet D-1

Date/Time Prepared:
11/27/2019 11:55 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,752,230	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,034,778	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					229,614	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					304,228	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					533,842	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,500,936	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					18,407	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					11,798	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					30,205	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,411	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,108.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,563,698	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0210

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

Worksheet D-1

Date/Time Prepared:
11/27/2019 11:55 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	473,967	6,775,557	0.069952	1,563,698	109,384
91.00	Nursing School cost	0	6,775,557	0.000000	1,563,698	0
92.00	Allied health cost	0	6,775,557	0.000000	1,563,698	0
93.00	All other Medical Education	0	6,775,557	0.000000	1,563,698	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/27/2019 11:55 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)		9,274	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,274	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)		9,274	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)		2,910	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)		6,809,521	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)		6,809,521	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)		6,809,521	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)		734.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,136,697	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)		2,136,697	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/27/2019 11:55 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)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					295,297 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,431,994 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					132,667 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					16,612 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					149,279 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,282,715 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0210 Component CCN: 14-S210		Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/27/2019 11:55 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	422,779	6,809,521	0.062086	0	0	90.00
91.00 Nursing School cost	0	6,809,521	0.000000	0	0	91.00
92.00 Allied health cost	0	6,809,521	0.000000	0	0	92.00
93.00 All other Medical Education	0	6,809,521	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/27/2019 11:55 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		3,446,051	30.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.629370	528,501	50.00
53.00	05300	ANESTHESIOLOGY	0.031111	473,360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.269517	449,458	54.00
54.01	05401	ULTRASOUND	0.111668	777,031	54.01
54.02	03440	MAMMOGRAPHY	0.440859	0	54.02
56.00	05600	RADIOISOTOPE	0.221784	240,591	56.00
57.00	05700	CT SCAN	0.046594	1,719,337	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.271325	19,977	58.00
60.00	06000	LABORATORY	0.189517	2,965,580	60.00
64.00	06400	INTRAVENOUS THERAPY	0.340262	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.201077	2,868,637	65.00
66.00	06600	PHYSICAL THERAPY	0.424318	402,409	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273023	280,768	67.00
68.00	06800	SPEECH PATHOLOGY	0.630716	19,315	68.00
69.00	06900	ELECTROCARDIOLOGY	0.134753	371,037	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105494	588,310	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.089058	545,279	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.278895	1,462,839	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.347299	92,766	75.00
76.00	03950	FAITH CENTER CHEMOTHERAPY	0.647914	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.235413	0	76.97
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	08804	RURAL HEALTH CLINIC V	0.000000		88.04
91.00	09100	EMERGENCY	0.226334	1,432,480	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.367523	515,168	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,752,843	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)		15,752,843	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/27/2019 11:55 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
40.00	04000 SUBPROVIDER - IPF		3,864,082		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.629370	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.031111	1,668	52	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.269517	18,696	5,039	54.00
54.01	05401 ULTRASOUND	0.111668	9,151	1,022	54.01
54.02	03440 MAMMOGRAPHY	0.440859	0	0	54.02
56.00	05600 RADIOISOTOPE	0.221784	7,044	1,562	56.00
57.00	05700 CT SCAN	0.046594	58,714	2,736	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.271325	0	0	58.00
60.00	06000 LABORATORY	0.189517	281,212	53,294	60.00
64.00	06400 INTRAVENOUS THERAPY	0.340262	2,855	971	64.00
65.00	06500 RESPIRATORY THERAPY	0.201077	220,358	44,309	65.00
66.00	06600 PHYSICAL THERAPY	0.424318	33,363	14,157	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.273023	9,172	2,504	67.00
68.00	06800 SPEECH PATHOLOGY	0.630716	820	517	68.00
69.00	06900 ELECTROCARDIOLOGY	0.134753	23,010	3,101	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105494	21,599	2,279	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.089058	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.278895	464,995	129,685	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.347299	0	0	75.00
76.00	03950 FAITH CENTER CHEMOTHERAPY	0.647914	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.235413	0	0	76.97
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	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100 EMERGENCY	0.226334	150,526	34,069	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.367523	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,303,183	295,297	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,303,183		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0210 Component CCN: 14-U210	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/27/2019 11:55 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.629370	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.031111	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.269517	1,406	379	54.00
54.01	05401 ULTRASOUND	0.111668	938	105	54.01
54.02	03440 MAMMOGRAPHY	0.440859	0	0	54.02
56.00	05600 RADIOISOTOPE	0.221784	0	0	56.00
57.00	05700 CT SCAN	0.046594	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.271325	0	0	58.00
60.00	06000 LABORATORY	0.189517	18,121	3,434	60.00
64.00	06400 INTRAVENOUS THERAPY	0.340262	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.201077	26,698	5,368	65.00
66.00	06600 PHYSICAL THERAPY	0.424318	39,196	16,632	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.273023	34,375	9,385	67.00
68.00	06800 SPEECH PATHOLOGY	0.630716	2,151	1,357	68.00
69.00	06900 ELECTROCARDIOLOGY	0.134753	1,077	145	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.105494	7,163	756	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.089058	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.278895	47,153	13,151	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.347299	327	114	75.00
76.00	03950 FAITH CENTER CHEMOTHERAPY	0.647914	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.235413	0	0	76.97
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	08804 RURAL HEALTH CLINIC V	0.000000		0	88.04
91.00	09100 EMERGENCY	0.226334	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.367523	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		178,605	50,826	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)		178,605		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/27/2019 11:55 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)		1,186,982	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,018,430	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		0	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		35.70	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.81	30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.01	31.00
32.00	Sum of lines 30 and 31		22.82	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.04	33.00
34.00	Disproportionate share adjustment (see instructions)		104,629	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/27/2019 11:55 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)		0.000028412	0.000079490	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		192,255	639,835	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		48,459	478,561	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		527,020		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)		5,837,061		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		6,166,064		48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)			6,166,064	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			426,809	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			6,592,873	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			6,592,873	61.00
62.00	Deductibles billed to program beneficiaries			883,036	62.00
63.00	Coinsurance billed to program beneficiaries			11,905	63.00
64.00	Allowable bad debts (see instructions)			271,959	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			176,773	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			224,020	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			5,874,705	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)			-13,574	70.92
70.93	HVBP payment adjustment amount (see instructions)			-43,278	70.93
70.94	HRR adjustment amount (see instructions)			0	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/27/2019 11:55 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	158,088	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	859,259	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,835,200	71.00
71.01	Sequestration adjustment (see instructions)		136,704	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		6,704,644	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)		-6,148	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/27/2019 11:55 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,186,982	0	1,186,982		1,186,982
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,018,430	0		4,018,430	4,018,430
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0804	0.0804	0.0804	0.0804	0
11.00	Disproportionate share adjustment (see instructions)	34.00	104,629	0	23,858	80,771	104,629
11.01	Uncompensated care payments	36.00	527,020	0	48,459	478,561	527,020
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	5,837,061	0	1,259,299	4,577,762	5,837,061
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,166,064	0	1,459,908	4,706,156	6,166,064
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,166,064	0	1,459,908	4,706,156	6,166,064
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	426,809	0	98,696	328,113	426,809
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/27/2019 11:55 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	1,558,604	5,034,269	6,592,873
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	426,809	0	98,696	328,113	426,809
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	426,809	0	98,696	328,113	426,809
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.101429	0.170682	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			158,088		158,088
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				859,259	859,259
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/27/2019 11:55 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		998	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,558,848	2.00
3.00	OPPS payments		5,194,517	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		998	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		3,686	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)		3,686	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)		3,686	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,688	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)		998	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		5,194,517	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,055,874	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,139,641	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,139,641	30.00
31.00	Primary payer payments		188	31.00
32.00	Subtotal (line 30 minus line 31)		4,139,453	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)		288,371	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		187,441	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		234,924	36.00
37.00	Subtotal (see instructions)		4,326,894	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)		4,326,894	40.00
40.01	Sequestration adjustment (see instructions)		86,538	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,285,087	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-44,731	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: 14-0210 Component CCN: 14-S210	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/27/2019 11:55 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		78	2.00
3.00	OPPS payments		56	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	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)		56	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)		11	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)		45	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)		45	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		45	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		45	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)		45	40.00
40.01	Sequestration adjustment (see instructions)		1	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		44	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/27/2019 11:55 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		6,704,644		4,285,087	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)		6,704,644		4,285,087	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		6,148		44,731	6.02	
7.00	Total Medicare program liability (see instructions)		6,698,496		4,240,356	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: 14-0210
 Component CCN: 14-S210

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/27/2019 11:55 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						1.00
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		2,453,729		44		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)		0		0		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)		2,453,729		44		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		30,675		0		6.02
7.00	Total Medicare program liability (see instructions)		2,423,054		44		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0210
 Component CCN: 14-U210

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/27/2019 11:55 am

		Title XVIII		Swing Beds - SNF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		35,888		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)		35,888		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		35,888		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: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/27/2019 11:55 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-0210

Period:

Worksheet E-2

Component CCN: 14-U210

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 am

		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		39,970	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		133	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		39,970	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		39,970	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		39,970	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		3,350	0	13.00
14.00	80% of Part B costs (line 12 x 80%)				14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		36,620	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		36,620	0	19.00
19.01	Sequestration adjustment (see instructions)		732	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		35,888	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210 Component CCN: 14-S210	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part II Date/Time Prepared: 11/27/2019 11:55 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)			2,655,292 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			886 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)			25.408219 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)			2,656,178 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)			2,656,178 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,656,178 18.00
19.00	Deductibles			252,644 19.00
20.00	Subtotal (line 18 minus line 19)			2,403,534 20.00
21.00	Coinurance			13,143 21.00
22.00	Subtotal (line 20 minus line 21)			2,390,391 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			126,328 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			82,113 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			102,239 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,472,504 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)			2,472,504 31.00
31.01	Sequestration adjustment (see instructions)			49,450 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,453,729 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)			-30,675 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: 14-0210

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

Worksheet G

Date/Time Prepared:
11/27/2019 11:55 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	1,346,562	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,243,590	0	0	0	4.00
5.00	Other receivable	200,998	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,461,405	0	0	0	7.00
8.00	Prepaid expenses	782,890	0	0	0	8.00
9.00	Other current assets	982,314	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)	14,017,759	0	0	0	11.00
FIXED ASSETS						
12.00	Land	839,600	0	0	0	12.00
13.00	Land improvements	893,892	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	37,372,745	0	0	0	15.00
16.00	Accumulated depreciation	-28,743,071	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	17,583,314	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	258,543	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	28,205,023	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,697,162	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	264,621	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,961,783	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,184,565	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,742,345	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,317,584	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	944,161	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,429,112	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,433,202	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	19,066,124	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,066,124	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	28,499,326	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	17,685,239				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)	17,685,239	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,184,565	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0210

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

Worksheet G-1

Date/Time Prepared:
11/27/2019 11:55 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		20,956,856		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,271,617				2.00
3.00	Total (sum of line 1 and line 2)		17,685,239		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)		17,685,239		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)		17,685,239		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: 14-0210

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/27/2019 11:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,341,276		5,341,276	1.00
2.00	SUBPROVIDER - IPF	12,535,369		12,535,369	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	80,765		80,765	5.00
6.00	Swing bed - NF	8,355		8,355	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	17,965,765		17,965,765	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	17,965,765		17,965,765	17.00
18.00	Ancillary services	19,678,877	73,269,841	92,948,718	18.00
19.00	Outpatient services	2,658,376	14,809,970	17,468,346	19.00
20.00	RURAL HEALTH CLINIC	0	2,878,913	2,878,913	20.00
20.01	RURAL HEALTH CLINIC II	0	42,762	42,762	20.01
20.02	RURAL HEALTH CLINIC III	0	444,807	444,807	20.02
20.03	RURAL HEALTH CLINIC IV	0	2,961,013	2,961,013	20.03
20.04	RURAL HEALTH CLINIC V	0	2,994,228	2,994,228	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		509,464	509,464	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES AND PHY PRIVATE OFFICE	2,626,517	13,710,019	16,336,536	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	42,929,535	111,621,017	154,550,552	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		59,640,123		29.00
30.00	FOUNDATION EXPENSES	90,389			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)		90,389		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)		59,730,512		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0210

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

Worksheet G-3

Date/Time Prepared:
11/27/2019 11:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	154,550,552	1.00
2.00	Less contractual allowances and discounts on patients' accounts	99,539,808	2.00
3.00	Net patient revenues (line 1 minus line 2)	55,010,744	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	59,730,512	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,719,768	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	34,400	6.00
7.00	Income from investments	157,698	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	1,072	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	99,653	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	24,550	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	5,479	21.00
22.00	Rental of hospital space	95,363	22.00
23.00	Governmental appropriations	0	23.00
24.00	340B REVENUE	734,303	24.00
24.01	INTEREST FROM AR	191,873	24.01
24.02	MISC INCOME	18,932	24.02
24.03	FOUNDATION INCOME	143,528	24.03
25.00	Total other income (sum of lines 6-24)	1,506,851	25.00
26.00	Total (line 5 plus line 25)	-3,212,917	26.00
27.00	FIXED ASSET DISPOSAL	58,700	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	58,700	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,271,617	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0210

Period:

Worksheet H

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 amHome Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	91,589	0	0	4,696	7,490	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	103,060	0	14,444	0	117,504	6.00
7.00	Physical Therapy	79,612	0	10,800	0	90,412	7.00
8.00	Occupational Therapy	5,125	0	1,235	0	6,360	8.00
9.00	Speech Pathology	2,766	0	294	0	3,060	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	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)	282,152	0	26,773	4,696	7,490	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	-41,256	62,519	0	62,519		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	117,504	0	117,504		6.00
7.00	Physical Therapy	0	90,412	0	90,412		7.00
8.00	Occupational Therapy	0	6,360	0	6,360		8.00
9.00	Speech Pathology	0	3,060	0	3,060		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	0	0	0		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)	-41,256	279,855	0	279,855		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: 14-0210

Period:

Worksheet H-1

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/27/2019 11:55 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	62,519	0	0	0	0	62,519	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	117,504	0	0	0	0	117,504	6.00
7.00	Physical Therapy	90,412	0	0	0	0	90,412	7.00
8.00	Occupational Therapy	6,360	0	0	0	0	6,360	8.00
9.00	Speech Pathology	3,060	0	0	0	0	3,060	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	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)	279,855	0	0	0	0	279,855	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	62,519						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	33,801	151,305					6.00
7.00	Physical Therapy	26,008	116,420					7.00
8.00	Occupational Therapy	1,830	8,190					8.00
9.00	Speech Pathology	880	3,940					9.00
10.00	Medical Social Services	0	0					10.00
11.00	Home Health Aide	0	0					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)		279,855					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0210

Period:

Worksheet H-1

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/27/2019 11:55 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	-62,519	5.00
						217,336	
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	117,504	6.00
7.00	Physical Therapy	0	0	0	0	90,412	7.00
8.00	Occupational Therapy	0	0	0	0	6,360	8.00
9.00	Speech Pathology	0	0	0	0	3,060	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	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	-62,519	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	62,519	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.287661	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0210

Period:

Worksheet H-2

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/27/2019 11:55 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				
1.00	Administrative and General	0	0	6,129	17,222	23,351	5,347	1.00
2.00	Skilled Nursing Care	151,305	0	0	34,282	185,587	42,501	2.00
3.00	Physical Therapy	116,420	0	0	26,483	142,903	32,725	3.00
4.00	Occupational Therapy	8,190	0	0	1,705	9,895	2,266	4.00
5.00	Speech Pathology	3,940	0	0	920	4,860	1,113	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)	279,855	0	6,129	80,612	366,596	83,952	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	0	0	9,622	0	1,279	1,506	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,646	3,114	2.00
3.00	Physical Therapy	0	0	0	0	2,037	2,398	3.00
4.00	Occupational Therapy	0	0	0	0	141	165	4.00
5.00	Speech Pathology	0	0	0	0	69	82	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	9,622	0	6,172	7,265	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: 14-0210

Period:

Worksheet H-2

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/27/2019 11:55 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Home Health Agency I Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	4,342	0	4,572	0	50,019	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	233,848	0	2.00
3.00	Physical Therapy	0	0	0	0	180,063	0	3.00
4.00	Occupational Therapy	0	0	0	0	12,467	0	4.00
5.00	Speech Pathology	0	0	0	0	6,124	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)	4,342	0	4,572	0	482,521	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	50,019						1.00
2.00	Skilled Nursing Care	233,848	27,045	260,893				2.00
3.00	Physical Therapy	180,063	20,824	200,887				3.00
4.00	Occupational Therapy	12,467	1,442	13,909				4.00
5.00	Speech Pathology	6,124	708	6,832				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
19.50	Telemedicine	0	0	0				19.50
20.00	Total (sum of lines 1-19) (2)	482,521	50,019	482,521				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.		0.115650					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: 14-0210

Period:

Worksheet H-2

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/27/2019 11:55 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	5,941	51,773	0	23,351	0	1.00
2.00	Skilled Nursing Care	0	0	103,060	0	185,587	0	2.00
3.00	Physical Therapy	0	0	79,612	0	142,903	0	3.00
4.00	Occupational Therapy	0	0	5,125	0	9,895	0	4.00
5.00	Speech Pathology	0	0	2,766	0	4,860	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	5,941	242,336		366,596	0	20.00
21.00	Total cost to be allocated	0	6,129	80,612		83,952	0	21.00
22.00	Unit cost multiplier	0.000000	1.031645	0.332646		0.229004	0.000000	22.00
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (MEALS SERVED)	CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	24	0	2,822	2,822	3,248	1.00
2.00	Skilled Nursing Care	0	0	0	5,835	5,835	0	2.00
3.00	Physical Therapy	0	0	0	4,494	4,494	0	3.00
4.00	Occupational Therapy	0	0	0	310	310	0	4.00
5.00	Speech Pathology	0	0	0	153	153	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	24	0	13,614	13,614	3,248	20.00
21.00	Total cost to be allocated	0	9,622	0	6,172	7,265	4,342	21.00
22.00	Unit cost multiplier	0.000000	400.916667	0.000000	0.453357	0.533642	1.336823	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0210

HHA CCN: 14-7419

Period:
From 07/01/2018
To 06/30/2019Worksheet H-2
Part II
Date/Time Prepared:
11/27/2019 11:55 am
PPS

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	Home Health Agency I	
		15.00	16.00	19.00		
1.00	Administrative and General	0	509,464	0		1.00
2.00	Skilled Nursing Care	0	0	0		2.00
3.00	Physical Therapy	0	0	0		3.00
4.00	Occupational Therapy	0	0	0		4.00
5.00	Speech Pathology	0	0	0		5.00
6.00	Medical Social Services	0	0	0		6.00
7.00	Home Health Aide	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0		8.00
9.00	Drugs	0	0	0		9.00
10.00	DME	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0		13.00
14.00	Clinic	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0		15.00
16.00	Day Care Program	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0		17.00
18.00	Homemaker Service	0	0	0		18.00
19.00	All Others (specify)	0	0	0		19.00
19.50	Telemedicine	0	0	0		19.50
20.00	Total (sum of lines 1-19)	0	509,464	0		20.00
21.00	Total cost to be allocated	0	4,572	0		21.00
22.00	Unit cost multiplier	0.000000	0.008974	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0210

Period:

Worksheet H-3

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/27/2019 11:55 am

				Title XVIII		Home Health Agency I	11/27/2019 11:55 am 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	260,893		260,893	1,181	220.91	1.00
2.00	Physical Therapy	3.00	200,887	0	200,887	883	227.51	2.00
3.00	Occupational Therapy	4.00	13,909	0	13,909	101	137.71	3.00
4.00	Speech Pathology	5.00	6,832	0	6,832	24	284.67	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		482,521	0	482,521	2,189		7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits			
					Part B			
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	645			8.00
9.00	Physical Therapy		99914	0	577			9.00
10.00	Occupational Therapy		99914	0	55			10.00
11.00	Speech Pathology		99914	0	25			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	0			13.00
14.00	Total (sum of lines 8-13)			0	1,302			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	1,305	1,305	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	15	15	54	0.277778	16.00
Cost Center Description		Part A	Program Visits		Cost of Services			
			Part B					
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
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	645		0	142,487		1.00
2.00	Physical Therapy	0	577		0	131,273		2.00
3.00	Occupational Therapy	0	55		0	7,574		3.00
4.00	Speech Pathology	0	25		0	7,117		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	1,302		0	288,451		7.00
Cost Center Description								
		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0210

Period:

Worksheet H-3

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:

11/27/2019 11:55 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1		
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	12,366	0	0	0	0	15.00
16.00	Cost of Drugs		54	0		15	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	142,487						1.00
2.00	Physical Therapy	131,273						2.00
3.00	Occupational Therapy	7,574						3.00
4.00	Speech Pathology	7,117						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	288,451						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0210

Period:

Worksheet H-3

HHA CCN: 14-7419

From 07/01/2018
To 06/30/2019Part II
Date/Time Prepared:
11/27/2019 11:55 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.424318	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.273023	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.630716	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.105494	12,366	1,305	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.278895	54	15	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0210 HHA CCN: 14-7419	Period: From 07/01/2018 To 06/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 11/27/2019 11:55 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	15	0	1.00
2.00	Total charges	0	54	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	54	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	39	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	15	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	265,325	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	13,764	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	4,617	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	283,721	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	283,721	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	283,721	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	283,721	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	283,721	31.00
31.01	Sequestration adjustment (see instructions)		0	5,675	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	278,083	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-37	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-0210
HHA CCN: 14-7419Period:
From 07/01/2018
To 06/30/2019

Worksheet H-5

Date/Time Prepared:
11/27/2019 11:55 am

		Home Health Agency I		PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		0		278,083
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		278,083
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		37
7.00	Total Medicare program liability (see instructions)		0		278,046
				Contractor Number	NPR Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor	0			

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/27/2019 11:55 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		426,809	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		12.80	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)		426,809	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: 14-0210

Period:

Worksheet M-1

Component CCN: 14-3473

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	462,891	0	462,891	0	462,891 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	345,539	0	345,539	0	345,539 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	204,854	0	204,854	0	204,854 5.00
6.00	Clinical Psychologist	52,760	0	52,760	0	52,760 6.00
7.00	Clinical Social Worker	44,819	0	44,819	0	44,819 7.00
8.00	Laboratory Technician	38,339	0	38,339	-38,339	0 8.00
9.00	Other Facility Health Care Staff Costs	54,276	0	54,276	-54,276	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	1,203,478	0	1,203,478	-92,615	1,110,863 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	1,961	1,961	51,688	53,649 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	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	1,961	1,961	51,688	53,649 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,203,478	1,961	1,205,439	-40,927	1,164,512 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	88,617	88,617	-51,688	36,929 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	88,617	88,617	-51,688	36,929 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	265,554	265,554	-22,731	242,823 29.00
30.00	Administrative Costs	235,500	115,155	350,655	-15,698	334,957 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	235,500	380,709	616,209	-38,429	577,780 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,438,978	471,287	1,910,265	-131,044	1,779,221 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-3473

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	462,891	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	345,539	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	204,854	5.00
6.00	Clinical Psychologist	0	52,760	6.00
7.00	Clinical Social Worker	0	44,819	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	1,110,863	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	53,649	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	53,649	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,164,512	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	36,929	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	36,929	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	242,823	29.00
30.00	Administrative Costs	0	334,957	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	577,780	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,779,221	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8518

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	10,737	0	10,737	0	10,737
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	3,183	0	3,183	0	3,183
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	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	13,920	0	13,920	0	13,920
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	3,586	0	3,586	0	3,586
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	3,586	0	3,586	0	3,586
15.00	Medical Supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	17,506	0	17,506	0	17,506
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	73	73	0	73
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	73	73	0	73
FACILITY OVERHEAD						
29.00	Facility Costs	0	4,551	4,551	0	4,551
30.00	Administrative Costs	1,433	1,567	3,000	891	3,891
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,433	6,118	7,551	891	8,442
32.00	Total facility costs (sum of lines 22, 28 and 31)	18,939	6,191	25,130	891	26,021

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8518

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	10,737	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	3,183	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	13,920	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	3,586	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	3,586	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	17,506	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	73	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	73	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	4,551	29.00
30.00	Administrative Costs	0	3,891	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	8,442	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	26,021	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8560

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	0	0	0	0	0
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	106,451	0	106,451	0	106,451
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	35,146	0	35,146	0	35,146
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	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	141,597	0	141,597	0	141,597
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	12,519	0	12,519	0	12,519
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	12,519	0	12,519	0	12,519
15.00	Medical Supplies	0	69	69	6,694	6,763
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	69	69	6,694	6,763
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	154,116	69	154,185	6,694	160,879
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	19,991	19,991	-6,694	13,297
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	19,991	19,991	-6,694	13,297
FACILITY OVERHEAD						
29.00	Facility Costs	0	23,173	23,173	-21,576	1,597
30.00	Administrative Costs	32,957	43,533	76,490	-4,548	71,942
31.00	Total Facility Overhead (sum of lines 29 and 30)	32,957	66,706	99,663	-26,124	73,539
32.00	Total facility costs (sum of lines 22, 28 and 31)	187,073	86,766	273,839	-26,124	247,715

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8560

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC III	Cost
		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	106,451		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	35,146		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	141,597		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	12,519		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	12,519		14.00
15.00	Medical Supplies	0	6,763		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,763		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	160,879		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	13,297		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	13,297		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	1,597		29.00
30.00	Administrative Costs	0	71,942		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	73,539		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	247,715		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8589

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 am

		RHC IV		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	432,381	0	432,381	0	432,381 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	257,298	0	257,298	0	257,298 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	163,183	0	163,183	0	163,183 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	49,086	0	49,086	0	49,086 8.00
9.00	Other Facility Health Care Staff Costs	61,810	0	61,810	0	61,810 9.00
10.00	Subtotal (sum of lines 1 through 9)	963,758	0	963,758	0	963,758 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	1,821	1,821	50,650	52,471 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	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	1,821	1,821	50,650	52,471 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	963,758	1,821	965,579	50,650	1,016,229 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	115,244	115,244	-50,650	64,594 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	115,244	115,244	-50,650	64,594 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	48,592	48,592	-14,158	34,434 29.00
30.00	Administrative Costs	181,498	380,328	561,826	-4,114	557,712 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	181,498	428,920	610,418	-18,272	592,146 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,145,256	545,985	1,691,241	-18,272	1,672,969 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8589

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	432,381	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	257,298	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	163,183	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	49,086	8.00
9.00	Other Facility Health Care Staff Costs	0	61,810	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	963,758	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	52,471	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	52,471	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,016,229	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	64,594	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	64,594	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	34,434	29.00
30.00	Administrative Costs	0	557,712	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	592,146	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,672,969	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8590

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	315,047	0	315,047	0	315,047 1.00
2.00	Physician Assistant	184,782	0	184,782	0	184,782 2.00
3.00	Nurse Practitioner	19,937	0	19,937	0	19,937 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	131,740	0	131,740	0	131,740 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	50,828	0	50,828	0	50,828 8.00
9.00	Other Facility Health Care Staff Costs	33,275	0	33,275	0	33,275 9.00
10.00	Subtotal (sum of lines 1 through 9)	735,609	0	735,609	0	735,609 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	1,920	1,920	37,968	39,888 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	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	1,920	1,920	37,968	39,888 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	735,609	1,920	737,529	37,968	775,497 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	87,873	87,873	-37,968	49,905 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	87,873	87,873	-37,968	49,905 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	167,092	167,092	-134,648	32,444 29.00
30.00	Administrative Costs	253,153	562,604	815,757	-5,809	809,948 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	253,153	729,696	982,849	-140,457	842,392 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	988,762	819,489	1,808,251	-140,457	1,667,794 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0210

Period:

Worksheet M-1

Component CCN: 14-8590

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	315,047	1.00
2.00	Physician Assistant	0	184,782	2.00
3.00	Nurse Practitioner	0	19,937	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	131,740	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	50,828	8.00
9.00	Other Facility Health Care Staff Costs	0	33,275	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	735,609	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	39,888	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,888	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	775,497	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	49,905	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	49,905	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	32,444	29.00
30.00	Administrative Costs	0	809,948	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	842,392	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,667,794	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-3473

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.62	5,397	4,200	6,804		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.65	9,461	2,100	5,565		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.27	14,858		12,369	14,858	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.45	1,875			1,875	6.00
7.00	Clinical Social Worker	0.78	1,033			1,033	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)	5.50	17,766			17,766	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,164,512	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					36,929	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,201,441	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.969263	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					577,780	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,689,003	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,266,783	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,266,783	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,197,109	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,361,621	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8518

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	4,200	0
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.10	259	2,100	210
4.00	Subtotal (sum of lines 1 through 3)	0.10	259	210	259
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.10	259		259
9.00	Physician Services Under Agreements		0		0
					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)				17,506
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				73
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				17,579
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.995847
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				8,442
15.00	Parent provider overhead allocated to facility (see instructions)				19,861
16.00	Total overhead (sum of lines 14 and 15)				28,303
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				28,303
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				28,185
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				45,691

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8560

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.94	2,288	2,100	1,974		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.94	2,288		1,974	2,288	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)	0.94	2,288			2,288	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)					160,879	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					13,297	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					174,176	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.923658	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					73,539	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					203,079	15.00
16.00	Total overhead (sum of lines 14 and 15)					276,618	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					276,618	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					255,500	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					416,379	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8589

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	1.00	5,568	4,200	4,200		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.57	7,493	2,100	3,297		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.57	13,061		7,497	13,061	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)	2.57	13,061			13,061	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,016,229	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					64,594	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,080,823	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.940236	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					592,146	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,377,005	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,969,151	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,969,151	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,851,467	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,867,696	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0210

Period:

Worksheet M-2

Component CCN: 14-8590

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/27/2019 11:55 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	0.80	4,070	4,200	3,360		1.00
2.00	Physician Assistant	0.90	4,516	2,100	1,890		2.00
3.00	Nurse Practitioner	0.17	4,701	2,100	357		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.87	13,287		5,607	13,287	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)	1.87	13,287			13,287	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)					775,497	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					49,905	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					825,402	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.939539	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					842,392	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,361,500	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,203,892	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,203,892	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,070,642	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,846,139	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/27/2019 11:55 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)			3,361,621	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			158,726	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,202,895	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,766	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)			17,766	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			180.28	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)			0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)			180.28	180.28	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	4,773	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	860,476	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	271	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	48,856	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	48,856	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	909,332	16.00
16.01	Total program charges (see instructions)(from contractor's records)				820,973	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				18,574	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				20,573	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.)				658,442	16.04
16.05	Total program cost (see instructions)			0	679,015	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				65,706	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				147,338	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				679,015	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				62,098	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				741,113	22.00
23.00	Allowable bad debts (see instructions)				46,900	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				30,485	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				44,893	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)				771,598	26.00
26.01	Sequestration adjustment (see instructions)				15,432	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				649,048	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)				107,118	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

Health Financial Systems		HARRISBURG MEDICAL CENTER, INC.		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-8518		Date/Time Prepared: 11/27/2019 11:55 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)			45,691	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			45,691	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			259	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)			259	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			176.41	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		176.41	176.41	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	53	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	9,350	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	9,350	16.00
16.01	Total program charges (see instructions)(from contractor's records)			9,343	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			311	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			311	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.)			7,110	16.04
16.05	Total program cost (see instructions)		0	7,421	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			152	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			1,776	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			7,421	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			7,421	22.00
23.00	Allowable bad debts (see instructions)			1,827	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			1,188	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,827	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)			8,609	26.00
26.01	Sequestration adjustment (see instructions)			172	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			7,949	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)			488	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: 14-0210 Component CCN: 14-8560	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/27/2019 11:55 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)			416,379	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			18,513	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			397,866	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,288	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)			2,288	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			173.89	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		173.89	173.89	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	435	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	75,642	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	75,642	16.00
16.01	Total program charges (see instructions)(from contractor's records)			69,256	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			95	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			104	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.)			54,773	16.04
16.05	Total program cost (see instructions)		0	54,877	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			7,072	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			12,437	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			54,877	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			5,077	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			59,954	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)			59,954	26.00
26.01	Sequestration adjustment (see instructions)			1,199	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			62,859	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)			-4,104	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HARRISBURG MEDICAL CENTER, INC.		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-8589		Date/Time Prepared: 11/27/2019 11:55 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)			2,867,696	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			153,074	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,714,622	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,061	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			13,061	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			207.84	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		207.84	207.84	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,258	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	677,143	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	17	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	3,533	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	3,533	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	680,676	16.00
16.01	Total program charges (see instructions)(from contractor's records)			556,758	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			11,820	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			14,451	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.)			483,014	16.04
16.05	Total program cost (see instructions)		0	497,465	16.05
17.00	Primary payer amounts			113	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			62,457	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			96,496	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			497,352	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			51,799	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			549,151	22.00
23.00	Allowable bad debts (see instructions)			10,063	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			6,541	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			10,063	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)			555,692	26.00
26.01	Sequestration adjustment (see instructions)			11,114	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			636,092	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)			-91,514	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

Health Financial Systems		HARRISBURG MEDICAL CENTER, INC.		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0210	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-8590		Date/Time Prepared: 11/27/2019 11:55 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)			2,846,139	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			150,196	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,695,943	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,287	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			13,287	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			202.90	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		202.90	202.90	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,683	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	747,281	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	103	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	20,899	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	20,899	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	768,180	16.00
16.01	Total program charges (see instructions)(from contractor's records)			660,617	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			14,672	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			17,061	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.)			551,992	16.04
16.05	Total program cost (see instructions)		0	569,053	16.05
17.00	Primary payer amounts			544	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			61,129	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			116,963	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			568,509	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			94,009	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			662,518	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)			662,518	26.00
26.01	Sequestration adjustment (see instructions)			13,250	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			557,389	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)			91,879	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: 14-0210 Component CCN: 14-3473	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/27/2019 11:55 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,110,863	1,110,863	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000749	0.002219	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		832	2,465	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		29,247	22,441	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		30,079	24,906	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,164,512	1,164,512	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,197,109	2,197,109	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.025830	0.021387	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		56,751	46,990	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		86,830	71,896	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		195	578	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		445.28	124.39	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		78	220	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		34,732	27,366	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)			158,726	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)			62,098	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0210 Component CCN: 14-8560	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/27/2019 11:55 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)		141,597	141,597	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000387	0.002852	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		55	404	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,025	3,669	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,080	4,073	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		160,879	160,879	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		255,500	255,500	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.019145	0.025317	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		4,892	6,468	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		7,972	10,541	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		19	140	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		419.58	75.29	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		6	34	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,517	2,560	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)			18,513	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)			5,077	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 14-0210
Component CCN: 14-8589Period:
From 07/01/2018
To 06/30/2019

Worksheet M-4

Date/Time Prepared:
11/27/2019 11:55 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)		963,758	963,758	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000945	0.002785	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		911	2,684	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		30,709	19,941	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		31,620	22,625	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,016,229	1,016,229	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,851,467	1,851,467	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.031115	0.022264	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		57,608	41,221	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		89,228	63,846	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		202	595	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		441.72	107.30	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		75	174	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		33,129	18,670	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)			153,074	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)			51,799	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0210 Component CCN: 14-8590	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/27/2019 11:55 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)		735,609	735,609	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001002	0.003017	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		737	2,219	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		20,191	17,777	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		20,928	19,996	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		775,497	775,497	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		2,070,642	2,070,642	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.026987	0.025785	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		55,880	53,392	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		76,808	73,388	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		169	509	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		454.49	144.18	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		125	258	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		56,811	37,198	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)			150,196	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)			94,009	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0210 Component CCN: 14-3473	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/27/2019 11:55 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		649,048	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)		649,048	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		107,118	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		756,166	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: 14-0210 Component CCN: 14-8518	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/27/2019 11:55 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			7,949	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)			7,949	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			488	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			8,437	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: 14-0210 Component CCN: 14-8560	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/27/2019 11:55 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			62,859	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)			62,859	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			0	6.01
6.02	SETTLEMENT TO PROGRAM			4,104	6.02
7.00	Total Medicare program liability (see instructions)			58,755	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: 14-0210 Component CCN: 14-8589	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/27/2019 11:55 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			331,692	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			02/06/2019	304,400	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)			304,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			636,092	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			0	6.01
6.02	SETTLEMENT TO PROGRAM			91,514	6.02
7.00	Total Medicare program liability (see instructions)			544,578	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: 14-0210 Component CCN: 14-8590	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/27/2019 11:55 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			343,689	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			02/06/2019	213,700	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)			213,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			557,389	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			91,879	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			649,268	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00