

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: 14-1327	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 3/30/2020 1:51 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 3/30/2020	Time: 1:51 pm
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (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 WABASH GENERAL HOSPITAL (14-1327) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KARISSA TURNER

Officer or Administrator of Provider(s)

CEO

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	18,240	-537,705	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-36,800	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		8,753		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-12,886		0	10.01
10.02	RURAL HEALTH CLINIC III	0		166,401		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		137,003		0	10.03
10.04	RURAL HEALTH CLINIC V	0		63,036		0	10.04
200.00	Total	0	-18,560	-175,398	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: 14-1327	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 3/30/2020 1:51 pm	
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	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863	County: WABASH	2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	

	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	WABASH GENERAL HOSPITAL	141327	99914	1	06/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	WABASH PRIMARY CARE	148568	14999		08/09/2016	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	WABASH PRIMARY CARE - COLLEGE DR	148579	14999		10/01/2017	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	WABASH PRIMARY CARE - OAK STREET	148599	14999		07/01/2019	N	O	N	15.03
15.04	Hospital-Based Health Clinic - RHC V	WABASH PRIMARY CARE - ALBION	148601	14999		08/09/2019	N	O	N	15.04
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	2		21.00

		1.00	2.00	3.00	
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	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		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.		2	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 3/30/2020 1:51 pm			
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
			1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00		
			Y/N	IME	Direct GME	IME	Direct GME		
			1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
			1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
							1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)									
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
				1.00	2.00	3.00			
64.00	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. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	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.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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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?			Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Y		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N	109.00
						1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1327	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 3/30/2020 1:51 pm	
			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.	N			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.	0			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	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)	Y			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1327		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 3/30/2020 1:51 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					N		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1327	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 3/30/2020 1:51 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/03/2020	Y
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: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
3/30/2020 1:51 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923508	SADAMS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	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	21	7,665	53,160.00	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)		21	7,665	53,160.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	1,296.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	54,456.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 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)		25				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: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,220	141	2,215			1.00
2.00	HMO and other (see instructions)	116	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	291	0	427			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,511	141	2,642			7.00
8.00	INTENSIVE CARE UNIT	18	0	54			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,529	141	2,696	0.00	284.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	310	0	3,833	0.00	1.82	26.00
26.01	RURAL HEALTH CLINIC II	2,011	0	12,813	0.00	20.27	26.01
26.02	RURAL HEALTH CLINIC III	4,470	0	8,136	0.00	8.43	26.02
26.03	RURAL HEALTH CLINIC IV	1,208	0	3,881	0.00	4.13	26.03
26.04	RURAL HEALTH CLINIC V	258	0	2,055	0.00	5.51	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	324.82	27.00
28.00	Observation Bed Days		0	214			28.00
29.00	Ambulance Trips	730					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: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	393	53	636	1.00
2.00 HMO and other (see instructions)			38	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	393	53	636	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 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-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8501		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 3/30/2020 1:51 pm	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1418 COLLEGE DRIVE			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			MT.CARMEL			IL 62863		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
9.01									9.01
9.02									9.02
9.03									9.03
9.04									9.04
9.05									9.05
9.06									9.06
9.07									9.07
9.08									9.08
9.09									9.09
9.10									9.10
				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			10:00 22:00		15:00 21:00		15:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N		0		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	

MCRIF32 - 15.12.167.2

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8568		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 3/30/2020 1:51 pm			
				RHC II		Cost					
				1.00							
Clinic Address and Identification											
1.00	Street			1123 CHESTNUT STREET			1.00				
				City		State		ZIP Code			
				1.00		2.00		3.00			
2.00	City, State, ZIP Code, County			MOUNT CARMEL IL 62863-1212			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		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			WABASH				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 18:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

From 01/01/2019

To 12/31/2019

Worksheet S-8

Component CCN: 14-8568

Date/Time Prepared:
3/30/2020 1:51 pm

RHC II

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

Health Financial Systems		WABASH GENERAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1327 Component CCN: 14-8579		Period: From 01/01/2019 To 12/31/2019 Worksheet S-8 Date/Time Prepared: 3/30/2020 1:51 pm	
		RHC III		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	1418 COLLEGE DR		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MOUNT CARMEL IL 62863		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		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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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	WABASH		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		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	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

Worksheet S-8

Component CCN: 14-8579

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

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	08:00	17:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

Worksheet S-8

Component CCN: 14-8599

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				RHC IV		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			1106 OAK STREET		1.00	
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			MOUNT CARMEL IL 62863		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?			Y		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			WABASH		2.00	
			Tuesday		Wednesday		Thursday
			to	from	to	from	to
			6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)							
11.00	CLINIC			17:00 08:00 17:00 08:00 17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

From 01/01/2019

To 12/31/2019

Worksheet S-8

Component CCN: 14-8599

Date/Time Prepared:
3/30/2020 1:51 pm

RHC IV

Cost

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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1327 Component CCN: 14-8601		Period: From 01/01/2019 To 12/31/2019		Worksheet S-8 Date/Time Prepared: 3/30/2020 1:51 pm	
				RHC V		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			26 EAST ELM STREET			1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County			ALBION IL 62806			2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00		
7.00	Appalachian Regional Commission						7.00		
8.00	Look-Alikes						8.00		
9.00	OTHER (SPECIFY)						9.00		
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N			0		10.00
				Sunday		Monday		Tuesday	
				from to		from to		from	
				1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)									
11.00	CLINIC			08:00			17:00		11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			Y			12.00		
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N			0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number						14.00		
				Y/N		V		Total Visits	
				1.00		2.00		3.00 4.00 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00		
				County					
				4.00					
2.00	City, State, ZIP Code, County			EDWARDS			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			09:00 18:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1327

Period:

Worksheet S-8

Component CCN: 14-8601

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

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	07:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1327

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

Worksheet S-10

Date/Time Prepared:
3/30/2020 1:51 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.387884	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		7,437,608	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		18,150,925	6.00
7.00	Medicaid cost (line 1 times line 6)		7,040,453	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)	373,347	0	373,347
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	144,815	0	144,815
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	144,815	0	144,815
			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)		4,280,803	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		369,559	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		568,552	27.01
28.00	Non-Medicare bad debt expense (see instructions)		3,712,251	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,638,916	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,783,731	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,783,731	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1327

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

Worksheet A

Date/Time Prepared:
3/30/2020 1:51 pm

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	NEW CAP REL COSTS-BLDG & FIXT		1,258,632	1,258,632	0	1,258,632 1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		817,605	817,605	758,752	1,576,357 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	190,516	5,119,957	5,310,473	0	5,310,473 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,041,962	4,648,021	6,689,983	-116,841	6,573,142 5.00
7.00	00700	OPERATION OF PLANT	276,260	1,241,150	1,517,410	-2,179	1,515,231 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	138,653	138,653 8.00
9.00	00900	HOUSEKEEPING	309,316	65,220	374,536	0	374,536 9.00
10.00	01000	DIETARY	392,648	262,027	654,675	-535,581	119,094 10.00
11.00	01100	CAFETERIA	0	0	0	533,478	533,478 11.00
13.00	01300	NURSING ADMINISTRATION	153,384	6,690	160,074	-12,111	147,963 13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	551,250	91,644	642,894	-2,508	640,386 16.00
17.00	01700	SOCIAL SERVICE	119,096	6,743	125,839	0	125,839 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	798,884	102,563	901,447	-16,902	884,545 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,391,152	1,015,567	2,406,719	-37,109	2,369,610 30.00
31.00	03100	INTENSIVE CARE UNIT	274,892	1,813	276,705	-72	276,633 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	838,181	3,806,256	4,644,437	-3,301,958	1,342,479 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	868,501	1,031,372	1,899,873	-140,741	1,759,132 54.00
60.00	06000	LABORATORY	836,444	847,540	1,683,984	-61,629	1,622,355 60.00
65.00	06500	RESPIRATORY THERAPY	675,035	134,566	809,601	-27,316	782,285 65.00
66.00	06600	PHYSICAL THERAPY	1,102,108	211,414	1,313,522	-14,078	1,299,444 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	230,427	146,136	376,563	754,771	1,131,334 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,695,511	2,695,511 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	377,637	2,728,128	3,105,765	-480	3,105,285 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	98,696	171,384	270,080	30	270,110 88.00
88.01	08802	RURAL HEALTH CLINIC II	1,723,365	294,796	2,018,161	-24,819	1,993,342 88.01
88.02	08801	RURAL HEALTH CLINIC III	802,114	75,270	877,384	-689	876,695 88.02
88.03	08803	RURAL HEALTH CLINIC IV	410,094	40,575	450,669	0	450,669 88.03
88.04	08804	RURAL HEALTH CLINIC V	349,606	99,412	449,018	25,478	474,496 88.04
90.00	09000	CLINIC	303,335	280,571	583,906	-187	583,719 90.00
90.01	09001	ORTHOPEAEDIC CLINIC	3,517,669	522,236	4,039,905	-221,146	3,818,759 90.01
90.02	09002	SURGICAL CLINIC	670,277	113,436	783,713	-12,241	771,472 90.02
90.03	09003	OP CLINIC	0	0	0	0	0 90.03
91.00	09100	EMERGENCY	1,037,597	1,262,600	2,300,197	-14,548	2,285,649 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	986,416	176,699	1,163,115	-27,966	1,135,149 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		317,691	317,691	-317,691	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,326,862	26,897,714	48,224,576	17,881	48,242,457 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	564,244	197,619	761,863	-17,881	743,982 192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	21,891,106	27,095,333	48,986,439	0	48,986,439 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1327

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

Worksheet A

Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	1,258,632	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-301,702	1,274,655	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-279,772	5,030,701	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-395,195	6,177,947	5.00
7.00	00700	OPERATION OF PLANT	0	1,515,231	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	138,653	8.00
9.00	00900	HOUSEKEEPING	0	374,536	9.00
10.00	01000	DIETARY	0	119,094	10.00
11.00	01100	CAFETERIA	-132,256	401,222	11.00
13.00	01300	NURSING ADMINISTRATION	0	147,963	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-21,675	618,711	16.00
17.00	01700	SOCIAL SERVICE	0	125,839	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-798,884	85,661	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-898,408	1,471,202	30.00
31.00	03100	INTENSIVE CARE UNIT	0	276,633	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,342,479	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,719	1,760,851	54.00
60.00	06000	LABORATORY	-64,728	1,557,627	60.00
65.00	06500	RESPIRATORY THERAPY	-29,087	753,198	65.00
66.00	06600	PHYSICAL THERAPY	0	1,299,444	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-14,705	1,116,629	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,695,511	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-461	3,104,824	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	270,110	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	1,993,342	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	876,695	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	450,669	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	474,496	88.04
90.00	09000	CLINIC	-215,500	368,219	90.00
90.01	09001	ORTHOPAEDIC CLINIC	-2,885,307	933,452	90.01
90.02	09002	SURGICAL CLINIC	-666,038	105,434	90.02
90.03	09003	OP CLINIC	0	0	90.03
91.00	09100	EMERGENCY	0	2,285,649	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	1,135,149	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,701,999	41,540,458	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	743,982	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-6,701,999	42,284,440	200.00

RECLASSIFICATIONS

Provider CCN: 14-1327

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

Worksheet A-6

Date/Time Prepared:
3/30/2020 1:51 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RENT					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	338,058		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
	0		0	338,058		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	320,990	212,488		1.00
	0		320,990	212,488		
	C - INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	317,691		1.00
	0		0	317,691		
	D - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,313		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	12,313		
	E - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	881,111		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	0		0	881,111		
	F - UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	13,447		1.00
2.00		0.00	0	0		2.00
	0		0	13,447		
	G - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,695,511		1.00
	0		0	2,695,511		
	H - LINEN					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	138,653		1.00
	0		0	138,653		
	I - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	103,003		1.00
	0		0	103,003		
	J - RHC RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	30	0		1.00
2.00	RURAL HEALTH CLINIC V	88.04	25,478	0		2.00
	TOTALS		25,508	0		
500.00	Grand Total: Increases		346,498	4,712,275		500.00

RECLASSIFICATIONS

Provider CCN: 14-1327

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

Worksheet A-6

Date/Time Prepared:
3/30/2020 1:51 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,838	10		1.00
2.00	OPERATION OF PLANT	7.00	0	15,626	0		2.00
3.00	DIETARY	10.00	0	2,103	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,508	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	2,508	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	139,712	0		6.00
7.00	LABORATORY	60.00	0	61,546	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	8,196	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	14,078	0		9.00
10.00	DRUGS CHARGED TO PATIENTS	73.00	0	480	0		10.00
11.00	CLINIC	90.00	0	187	0		11.00
12.00	ORTHOPAEDIC CLINIC	90.01	0	39,017	0		12.00
13.00	EMERGENCY	91.00	0	771	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	26,432	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,056	0		15.00
	0		0	338,058			
	B - CAFETERIA						
1.00	DIETARY	10.00	320,990	212,488	0		1.00
	0		320,990	212,488			
	C - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	317,691	9		1.00
	0		0	317,691			
	D - OXYGEN						
1.00	OPERATING ROOM	50.00	0	339	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	11,131	0		2.00
3.00	AMBULANCE SERVICES	95.00	0	843	0		3.00
	0		0	12,313			
	E - MED SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00	0	12,111	0		1.00
2.00	NONPHYSICIAN ANESTHETISTS	19.00	0	16,902	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	34,601	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	72	0		4.00
5.00	OPERATING ROOM	50.00	0	606,108	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,029	0		6.00
7.00	LABORATORY	60.00	0	83	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	7,989	0		8.00
9.00	ORTHOPAEDIC CLINIC	90.01	0	182,129	0		9.00
10.00	SURGICAL CLINIC	90.02	0	5,404	0		10.00
11.00	EMERGENCY	91.00	0	13,777	0		11.00
12.00	AMBULANCE SERVICES	95.00	0	691	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	215	0		13.00
	0		0	881,111			
	F - UTILITIES						
1.00	SURGICAL CLINIC	90.02	0	6,837	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,610	0		2.00
	0		0	13,447			
	G - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	2,695,511	0		1.00
	0		0	2,695,511			
	H - LINEN						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	138,653	0		1.00
	0		0	138,653			
	I - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	103,003	9		1.00
	0		0	103,003			
	J - RHC RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	24,819	0	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	689	0	0		2.00
	TOTALS		25,508	0			
500.00	Grand Total: Decreases		346,498	4,712,275			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

		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	467,367	79,547	0	79,547	0	1.00	
2.00	Land Improvements	2,088,063	13,765	0	13,765	0	2.00	
3.00	Buildings and Fixtures	25,424,261	2,117,794	0	2,117,794	0	3.00	
4.00	Building Improvements	26,944	0	0	0	26,944	4.00	
5.00	Fixed Equipment	4,866,438	52,978	0	52,978	0	5.00	
6.00	Movable Equipment	15,170,915	848,991	0	848,991	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	48,043,988	3,113,075	0	3,113,075	26,944	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	48,043,988	3,113,075	0	3,113,075	26,944	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	546,914	0				1.00	
2.00	Land Improvements	2,101,828	0				2.00	
3.00	Buildings and Fixtures	27,542,055	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	4,919,416	0				5.00	
6.00	Movable Equipment	16,019,906	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	51,130,119	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	51,130,119	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,258,632	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	817,605	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,076,237	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,258,632				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	817,605				2.00
3.00	Total (sum of lines 1-2)	0	2,076,237				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	35,110,213	0	35,110,213	0.686684	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	16,019,906	0	16,019,906	0.313316	0	2.00
3.00	Total (sum of lines 1-2)	51,130,119	0	51,130,119	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,258,632	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	936,597	338,058	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,195,229	338,058	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,258,632	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,274,655	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,533,287	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1327

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

Worksheet A-8

Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-317,691	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-20,028	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,759,251			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	1,902			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-132,256	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-14,705	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-461	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-21,675	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1327

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

Worksheet A-8

Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DIETARY	B	0	DIETARY	10.00	0	33.00
34.00	A&G OTHER REVENUE	B	-79,153	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHYSICIAN RECRUITMENT	A	-281,463	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PHYSICIAN RECRUITMENT	A	-64,162	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	PUBLIC RELATIONS	A	-78,442	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
37.00	LOBBYING DUES	A	-14,551	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	CRNA SALARY	A	-798,884	NONPHYSICIAN ANESTHETISTS	19.00	0	38.00
39.00	CRNA EMP BEN	A	-137,168	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	BOND INSURANCE	A	15,989	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	40.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,701,999				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1327

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

Worksheet A-8-1

Date/Time Prepared:
3/30/2020 1:51 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	316,061	314,159	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	316,061	314,159	5.00

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

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

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

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

6.00	A	DSS MRI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1327

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

Worksheet A-8-1

Date/Time Prepared:
3/30/2020 1:51 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1,902	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	1,902			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1327

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

Worksheet A-8-2

Date/Time Prepared:
3/30/2020 1:51 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	898,408	898,408	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	183	183	0	0	0	2.00
3.00	60.00	LABORATORY	64,728	64,728	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	29,087	29,087	0	0	0	4.00
5.00	90.00	CLINIC	215,500	215,500	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	3,000,452	2,885,307	115,145	0	0	6.00
7.00	90.02	SURGICAL CLINIC	679,289	666,038	13,251	0	0	7.00
8.00	91.00	EMERGENCY	1,114,000	0	1,114,000	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,001,647	4,759,251	1,242,396		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	898,408		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	183		2.00
3.00	60.00	LABORATORY	0	0	0	64,728		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	29,087		4.00
5.00	90.00	CLINIC	0	0	0	215,500		5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	2,885,307		6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	666,038		7.00
8.00	91.00	EMERGENCY	0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	4,759,251		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,258,632	1,258,632			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,274,655		1,274,655		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,030,701	5,964	6,040	5,042,705	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,177,947	81,448	82,485	474,503	5.00
7.00	00700	OPERATION OF PLANT	1,515,231	48,347	48,962	64,196	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	138,653	0	0	0	8.00
9.00	00900	HOUSEKEEPING	374,536	4,737	4,797	71,878	9.00
10.00	01000	DIETARY	119,094	36,994	37,465	16,652	10.00
11.00	01100	CAFETERIA	401,222	14,882	15,071	74,590	11.00
13.00	01300	NURSING ADMINISTRATION	147,963	2,800	2,836	35,643	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	618,711	16,359	16,567	128,097	16.00
17.00	01700	SOCIAL SERVICE	125,839	3,414	3,457	27,675	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	85,661	0	0	185,641	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,471,202	151,350	153,277	323,270	30.00
31.00	03100	INTENSIVE CARE UNIT	276,633	15,285	15,479	63,878	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,342,479	237,034	240,055	194,773	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,760,851	50,591	51,235	201,819	54.00
60.00	06000	LABORATORY	1,557,627	36,073	36,532	194,370	60.00
65.00	06500	RESPIRATORY THERAPY	753,198	15,841	16,042	156,862	65.00
66.00	06600	PHYSICAL THERAPY	1,299,444	78,245	79,241	256,103	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,116,629	45,087	45,661	53,546	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,695,511	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,104,824	10,644	10,779	87,754	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	270,110	17,912	18,140	22,942	88.00
88.01	08802	RURAL HEALTH CLINIC II	1,993,342	0	0	394,701	88.01
88.02	08801	RURAL HEALTH CLINIC III	876,695	76,711	77,687	186,232	88.02
88.03	08803	RURAL HEALTH CLINIC IV	450,669	0	0	95,296	88.03
88.04	08804	RURAL HEALTH CLINIC V	474,496	0	0	87,161	88.04
90.00	09000	CLINIC	368,219	38,950	39,446	70,488	90.00
90.01	09001	ORTHOPAEDIC CLINIC	933,452	148,646	150,539	817,430	90.01
90.02	09002	SURGICAL CLINIC	105,434	0	0	155,756	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,285,649	42,881	43,427	241,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,135,149	68,426	69,297	229,219	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,540,458	1,248,621	1,264,517	4,911,588	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,219	4,273	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	743,982	5,792	5,865	131,117	192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,284,440	1,258,632	1,274,655	5,042,705	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

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	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,816,383				5.00
7.00	00700	OPERATION OF PLANT	322,242	1,998,978			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,647	0	165,300		8.00
9.00	00900	HOUSEKEEPING	87,626	9,209	768	553,551	9.00
10.00	01000	DIETARY	40,398	71,918	2,752	20,007	345,280
11.00	01100	CAFETERIA	97,200	28,931	0	8,049	0
13.00	01300	NURSING ADMINISTRATION	36,369	5,443	0	1,514	0
16.00	01600	MEDICAL RECORDS & LIBRARY	149,852	31,802	0	8,847	0
17.00	01700	SOCIAL SERVICE	30,823	6,636	0	1,846	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	52,140	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	403,413	294,234	63,322	81,855	337,077
31.00	03100	INTENSIVE CARE UNIT	71,353	29,714	0	8,266	8,203
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	387,124	460,814	29,695	128,200	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	396,763	98,351	17,444	27,361	0
60.00	06000	LABORATORY	350,659	70,128	649	19,510	0
65.00	06500	RESPIRATORY THERAPY	181,026	30,795	4,069	8,567	0
66.00	06600	PHYSICAL THERAPY	329,218	152,113	15,945	42,318	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	242,329	87,651	0	24,384	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	518,034	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	617,671	20,692	0	5,756	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	63,249	0	0	0	0
88.01	08802	RURAL HEALTH CLINIC II	458,944	0	219	0	0
88.02	08801	RURAL HEALTH CLINIC III	233,950	0	0	0	0
88.03	08803	RURAL HEALTH CLINIC IV	104,926	0	0	0	0
88.04	08804	RURAL HEALTH CLINIC V	107,941	0	558	0	0
90.00	09000	CLINIC	99,379	75,721	1,381	21,065	0
90.01	09001	ORTHOPAEDIC CLINIC	393,990	288,977	0	80,393	0
90.02	09002	SURGICAL CLINIC	50,197	0	0	0	0
90.03	09003	OP CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	502,190	83,364	26,971	23,192	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	288,678	133,024	1,344	37,007	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,644,331	1,979,517	165,117	548,137	345,280
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,632	8,202	0	2,282	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	170,420	11,259	183	3,132	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	6,816,383	1,998,978	165,300	553,551	345,280

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	639,945					11.00
13.00	01300	NURSING ADMINISTRATION	5,320	237,888				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,735	0	1,016,970			16.00
17.00	01700	SOCIAL SERVICE	7,071	0	0	206,761		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	323,442	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91,719	101,967	160,162	201,840	0	30.00
31.00	03100	INTENSIVE CARE UNIT	16,061	17,856	0	4,921	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	51,516	57,273	124,046	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	323,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54,479	0	48,676	0	0	54.00
60.00	06000	LABORATORY	47,880	0	26,693	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	35,018	0	28,264	0	0	65.00
66.00	06600	PHYSICAL THERAPY	56,432	0	13,085	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,960	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,748	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	89,502	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	83,744	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	101,017	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	40,825	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	34,021	0	0	88.04
90.00	09000	CLINIC	17,812	0	53,910	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	108,082	0	111,485	0	0	90.01
90.02	09002	SURGICAL CLINIC	16,431	0	24,600	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	54,681	60,792	69,089	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	7,851	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	639,945	237,888	1,016,970	206,761	323,442	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
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)	639,945	237,888	1,016,970	206,761	323,442	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW 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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,834,688	0	3,834,688	30.00
31.00	03100	INTENSIVE CARE UNIT	527,649	0	527,649	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,253,009	0	3,253,009	50.00
53.00	05300	ANESTHESIOLOGY	323,442	0	323,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,707,570	0	2,707,570	54.00
60.00	06000	LABORATORY	2,340,121	0	2,340,121	60.00
65.00	06500	RESPIRATORY THERAPY	1,229,682	0	1,229,682	65.00
66.00	06600	PHYSICAL THERAPY	2,322,144	0	2,322,144	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,631,247	0	1,631,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,213,545	0	3,213,545	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,872,868	0	3,872,868	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	481,855	0	481,855	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,930,950	0	2,930,950	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,552,292	0	1,552,292	88.02
88.03	08803	RURAL HEALTH CLINIC IV	691,716	0	691,716	88.03
88.04	08804	RURAL HEALTH CLINIC V	704,177	0	704,177	88.04
90.00	09000	CLINIC	786,371	0	786,371	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,032,994	0	3,032,994	90.01
90.02	09002	SURGICAL CLINIC	352,418	0	352,418	90.02
90.03	09003	OP CLINIC	0	0	0	90.03
91.00	09100	EMERGENCY	3,433,349	0	3,433,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,969,995	0	1,969,995	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,192,082	0	41,192,082	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,608	0	20,608	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,071,750	0	1,071,750	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,284,440	0	42,284,440	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,964	6,040	12,004	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,838	81,448	82,485	177,771	5.00
7.00	00700	OPERATION OF PLANT	15,626	48,347	48,962	112,935	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	4,737	4,797	9,534	9.00
10.00	01000	DIETARY	2,103	36,994	37,465	76,562	10.00
11.00	01100	CAFETERIA	0	14,882	15,071	29,953	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,800	2,836	5,636	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,508	16,359	16,567	35,434	16.00
17.00	01700	SOCIAL SERVICE	0	3,414	3,457	6,871	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,508	151,350	153,277	307,135	30.00
31.00	03100	INTENSIVE CARE UNIT	0	15,285	15,479	30,764	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	237,034	240,055	477,089	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,712	50,591	51,235	241,538	54.00
60.00	06000	LABORATORY	61,546	36,073	36,532	134,151	60.00
65.00	06500	RESPIRATORY THERAPY	8,016	15,841	16,042	39,899	65.00
66.00	06600	PHYSICAL THERAPY	14,078	78,245	79,241	171,564	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	45,087	45,661	90,748	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	480	10,644	10,779	21,903	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	17,912	18,140	36,052	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	76,711	77,687	154,398	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	0	88.04
90.00	09000	CLINIC	187	38,950	39,446	78,583	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	148,646	150,539	299,185	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	42,881	43,427	86,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	26,432	68,426	69,297	164,155	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	287,034	1,248,621	1,264,517	2,800,172	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,219	4,273	8,492	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,792	5,865	11,657	192.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	287,034	1,258,632	1,274,655	2,820,321	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	178,900					5.00
7.00	00700	OPERATION OF PLANT	8,457	121,545				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	699	0	699			8.00
9.00	00900	HOUSEKEEPING	2,300	560	3	12,568		9.00
10.00	01000	DIETARY	1,060	4,373	12	454	82,501	10.00
11.00	01100	CAFETERIA	2,551	1,759	0	183	0	11.00
13.00	01300	NURSING ADMINISTRATION	955	331	0	34	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,933	1,934	0	201	0	16.00
17.00	01700	SOCIAL SERVICE	809	404	0	42	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,368	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,588	17,890	267	1,858	80,541	30.00
31.00	03100	INTENSIVE CARE UNIT	1,873	1,807	0	188	1,960	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,160	28,018	126	2,910	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,413	5,980	74	621	0	54.00
60.00	06000	LABORATORY	9,203	4,264	3	443	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,751	1,872	17	195	0	65.00
66.00	06600	PHYSICAL THERAPY	8,641	9,249	67	961	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,360	5,330	0	554	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,596	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,212	1,258	0	131	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,660	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	12,045	0	1	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	6,140	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	2,754	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	2,833	0	2	0	0	88.04
90.00	09000	CLINIC	2,608	4,604	6	478	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	10,341	17,571	0	1,825	0	90.01
90.02	09002	SURGICAL CLINIC	1,317	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	13,180	5,069	114	527	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	7,577	8,088	6	840	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	174,384	120,361	698	12,445	82,501	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43	499	0	52	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,473	685	1	71	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	178,900	121,545	699	12,568	82,501	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW 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	34,624					11.00
13.00	01300 NURSING ADMINISTRATION	288	7,329				13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2,529	0	44,336			16.00
17.00	01700 SOCIAL SERVICE	383	0	0	8,575		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,810	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,962	3,142	6,984	8,371		30.00
31.00	03100 INTENSIVE CARE UNIT	869	550	0	204		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,787	1,764	5,408	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,948	0	2,122	0		54.00
60.00	06000 LABORATORY	2,591	0	1,164	0		60.00
65.00	06500 RESPIRATORY THERAPY	1,895	0	1,232	0		65.00
66.00	06600 PHYSICAL THERAPY	3,053	0	570	0		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	864	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	798	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	3,902	0		88.00
88.01	08802 RURAL HEALTH CLINIC II	0	0	3,651	0		88.01
88.02	08801 RURAL HEALTH CLINIC III	0	0	4,404	0		88.02
88.03	08803 RURAL HEALTH CLINIC IV	0	0	1,780	0		88.03
88.04	08804 RURAL HEALTH CLINIC V	0	0	1,483	0		88.04
90.00	09000 CLINIC	964	0	2,350	0		90.00
90.01	09001 ORTHOPAEDIC CLINIC	5,845	0	4,860	0		90.01
90.02	09002 SURGICAL CLINIC	889	0	1,072	0		90.02
90.03	09003 OP CLINIC	0	0	0	0		90.03
91.00	09100 EMERGENCY	2,959	1,873	3,012	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	342	0		95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	34,624	7,329	44,336	8,575	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00	Cross Foot Adjustments					1,810	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	34,624	7,329	44,336	8,575	1,810	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW 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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	442,507	0	442,507	30.00
31.00	03100	INTENSIVE CARE UNIT	38,367	0	38,367	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	528,726	0	528,726	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	264,176	0	264,176	54.00
60.00	06000	LABORATORY	152,282	0	152,282	60.00
65.00	06500	RESPIRATORY THERAPY	50,234	0	50,234	65.00
66.00	06600	PHYSICAL THERAPY	194,714	0	194,714	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,983	0	103,983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,596	0	13,596	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,511	0	40,511	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	41,669	0	41,669	88.00
88.01	08802	RURAL HEALTH CLINIC II	16,636	0	16,636	88.01
88.02	08801	RURAL HEALTH CLINIC III	165,385	0	165,385	88.02
88.03	08803	RURAL HEALTH CLINIC IV	4,761	0	4,761	88.03
88.04	08804	RURAL HEALTH CLINIC V	4,525	0	4,525	88.04
90.00	09000	CLINIC	89,761	0	89,761	90.00
90.01	09001	ORTHOPAEDIC CLINIC	341,575	0	341,575	90.01
90.02	09002	SURGICAL CLINIC	3,649	0	3,649	90.02
90.03	09003	OP CLINIC	0	0	0	90.03
91.00	09100	EMERGENCY	113,616	0	113,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	181,553	0	181,553	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,792,226	0	2,792,226	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,086	0	9,086	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	17,199	0	17,199	192.00
200.00		Cross Foot Adjustments	1,810	0	1,810	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,820,321	0	2,820,321	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1327

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	65,630				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		65,630			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	311	311	21,700,590		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,247	4,247	2,041,962	-6,816,383	5.00
7.00	00700	OPERATION OF PLANT	2,521	2,521	276,260	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	247	247	309,316	0	9.00
10.00	01000	DIETARY	1,929	1,929	71,658	0	10.00
11.00	01100	CAFETERIA	776	776	320,990	0	11.00
13.00	01300	NURSING ADMINISTRATION	146	146	153,384	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	853	551,250	0	16.00
17.00	01700	SOCIAL SERVICE	178	178	119,096	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	798,884	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,892	7,892	1,391,152	0	30.00
31.00	03100	INTENSIVE CARE UNIT	797	797	274,892	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,360	12,360	838,181	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,638	868,501	0	54.00
60.00	06000	LABORATORY	1,881	1,881	836,444	0	60.00
65.00	06500	RESPIRATORY THERAPY	826	826	675,035	0	65.00
66.00	06600	PHYSICAL THERAPY	4,080	4,080	1,102,108	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	2,351	230,427	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	555	377,637	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	934	934	98,726	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	1,698,546	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	4,000	4,000	801,425	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	410,094	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	375,084	0	88.04
90.00	09000	CLINIC	2,031	2,031	303,335	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,751	7,751	3,517,669	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	670,277	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,236	2,236	1,037,597	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,568	3,568	986,416	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,108	65,108	21,136,346	-6,816,383	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	220	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	302	564,244	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,258,632	1,274,655	5,042,705	6,816,383	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.177693	19.421835	0.232376	0.192184	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,004	178,900	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000553	0.005044	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: 14-1327

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	53,617				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,080			8.00
9.00	00900	HOUSEKEEPING	247	84	53,370		9.00
10.00	01000	DIETARY	1,929	301	1,929	6,945	10.00
11.00	01100	CAFETERIA	776	0	776	0	11.00
13.00	01300	NURSING ADMINISTRATION	146	0	146	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	0	853	0	16.00
17.00	01700	SOCIAL SERVICE	178	0	178	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,892	6,926	7,892	6,780	30.00
31.00	03100	INTENSIVE CARE UNIT	797	0	797	165	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,360	3,248	12,360	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	1,908	2,638	0	54.00
60.00	06000	LABORATORY	1,881	71	1,881	0	60.00
65.00	06500	RESPIRATORY THERAPY	826	445	826	0	65.00
66.00	06600	PHYSICAL THERAPY	4,080	1,744	4,080	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,351	0	2,351	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	0	555	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	24	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	61	0	0	88.04
90.00	09000	CLINIC	2,031	151	2,031	0	90.00
90.01	09001	ORTHOPEAEDIC CLINIC	7,751	0	7,751	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,236	2,950	2,236	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,568	147	3,568	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,095	18,060	52,848	6,945	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	0	220	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	20	302	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,998,978	165,300	553,551	345,280	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.282541	9.142699	10.371951	49.716343	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	121,545	699	12,568	82,501	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.266912	0.038662	0.235488	11.879194	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: 14-1327

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	6,355				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,943			16.00
17.00	01700	SOCIAL SERVICE	0	0	2,269		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,724	306	2,215	0	30.00
31.00	03100	INTENSIVE CARE UNIT	477	0	54	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,530	237	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	93	0	0	54.00
60.00	06000	LABORATORY	0	51	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	54	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	171	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	160	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	193	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	78	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	65	0	0	88.04
90.00	09000	CLINIC	0	103	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	213	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	47	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,624	132	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	15	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,355	1,943	2,269	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	237,888	1,016,970	206,761	323,442	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.433202	523.401956	91.124284	3,234.420000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,329	44,336	8,575	1,810	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.153265	22.818322	3.779198	18.100000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,834,688		3,834,688	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	527,649		527,649	0	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,253,009		3,253,009	0	0	50.00
53.00	05300	ANESTHESIOLOGY	323,442		323,442	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,707,570		2,707,570	0	0	54.00
60.00	06000	LABORATORY	2,340,121		2,340,121	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,229,682	0	1,229,682	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,322,144	0	2,322,144	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,631,247		1,631,247	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,213,545		3,213,545	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,872,868		3,872,868	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	481,855		481,855	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	2,930,950		2,930,950	0	0	88.01
88.02	08801	RURAL HEALTH CLINIC III	1,552,292		1,552,292	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	691,716		691,716	0	0	88.03
88.04	08804	RURAL HEALTH CLINIC V	704,177		704,177	0	0	88.04
90.00	09000	CLINIC	786,371		786,371	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	3,032,994		3,032,994	0	0	90.01
90.02	09002	SURGICAL CLINIC	352,418		352,418	0	0	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	3,433,349		3,433,349	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	287,334		287,334	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,969,995		1,969,995	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	41,479,416	0	41,479,416	0	0	200.00
201.00		Less Observation Beds	287,334		287,334			201.00
202.00		Total (see instructions)	41,192,082	0	41,192,082	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,635,128		2,635,128			30.00
31.00	03100	INTENSIVE CARE UNIT	81,439		81,439			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,791,270	8,011,244	18,802,514	0.173009	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,277,614	1,814,938	3,092,552	0.104587	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,514	17,150,030	17,763,544	0.152423	0.000000	54.00
60.00	06000	LABORATORY	1,041,720	13,853,746	14,895,466	0.157103	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	312,167	2,539,961	2,852,128	0.431145	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,187,413	5,201,352	6,388,765	0.363473	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,885,743	317,978	3,203,721	0.509173	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,764,853	250,000	12,014,853	0.267464	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,512,398	9,450,613	10,963,011	0.353267	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	471,275	471,275			88.00
88.01	08802	RURAL HEALTH CLINIC II	0	2,057,591	2,057,591			88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,179,626	1,179,626			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	451,470	451,470			88.03
88.04	08804	RURAL HEALTH CLINIC V	0	210,613	210,613			88.04
90.00	09000	CLINIC	1,000	828,592	829,592	0.947901	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	1,798,466	1,798,466	1.686434	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	258,986	258,986	1.360761	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	33,431	4,578,172	4,611,603	0.744502	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,269	233,928	245,197	1.171850	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,389,376	1,389,376	1.417899	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,148,959	72,047,957	106,196,916			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	34,148,959	72,047,957	106,196,916			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08802	RURAL HEALTH CLINIC II			88.01
88.02	08801	RURAL HEALTH CLINIC III			88.02
88.03	08803	RURAL HEALTH CLINIC IV			88.03
88.04	08804	RURAL HEALTH CLINIC V			88.04
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,834,688		3,834,688	0	3,834,688	30.00	
31.00	03100	INTENSIVE CARE UNIT	527,649		527,649	0	527,649	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,253,009		3,253,009	0	3,253,009	50.00	
53.00	05300	ANESTHESIOLOGY	323,442		323,442	0	323,442	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,707,570		2,707,570	0	2,707,570	54.00	
60.00	06000	LABORATORY	2,340,121		2,340,121	0	2,340,121	60.00	
65.00	06500	RESPIRATORY THERAPY	1,229,682	0	1,229,682	0	1,229,682	65.00	
66.00	06600	PHYSICAL THERAPY	2,322,144	0	2,322,144	0	2,322,144	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,631,247		1,631,247	0	1,631,247	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,213,545		3,213,545	0	3,213,545	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,872,868		3,872,868	0	3,872,868	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	481,855		481,855	0	481,855	88.00	
88.01	08802	RURAL HEALTH CLINIC II	2,930,950		2,930,950	0	2,930,950	88.01	
88.02	08801	RURAL HEALTH CLINIC III	1,552,292		1,552,292	0	1,552,292	88.02	
88.03	08803	RURAL HEALTH CLINIC IV	691,716		691,716	0	691,716	88.03	
88.04	08804	RURAL HEALTH CLINIC V	704,177		704,177	0	704,177	88.04	
90.00	09000	CLINIC	786,371		786,371	0	786,371	90.00	
90.01	09001	ORTHOPAEDIC CLINIC	3,032,994		3,032,994	0	3,032,994	90.01	
90.02	09002	SURGICAL CLINIC	352,418		352,418	0	352,418	90.02	
90.03	09003	OP CLINIC	0		0	0	0	90.03	
91.00	09100	EMERGENCY	3,433,349		3,433,349	0	3,433,349	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	287,334		287,334	0	287,334	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,969,995		1,969,995	0	1,969,995	95.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	41,479,416	0	41,479,416	0	41,479,416	200.00	
201.00		Less Observation Beds	287,334		287,334		287,334	201.00	
202.00		Total (see instructions)	41,192,082	0	41,192,082	0	41,192,082	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,635,128		2,635,128			30.00
31.00	03100	INTENSIVE CARE UNIT	81,439		81,439			31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,791,270	8,011,244	18,802,514	0.173009	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,277,614	1,814,938	3,092,552	0.104587	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	613,514	17,150,030	17,763,544	0.152423	0.000000	54.00
60.00	06000	LABORATORY	1,041,720	13,853,746	14,895,466	0.157103	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	312,167	2,539,961	2,852,128	0.431145	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,187,413	5,201,352	6,388,765	0.363473	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,885,743	317,978	3,203,721	0.509173	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,764,853	250,000	12,014,853	0.267464	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,512,398	9,450,613	10,963,011	0.353267	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	471,275	471,275	1.022450	0.000000	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	2,057,591	2,057,591	1.424457	0.000000	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	1,179,626	1,179,626	1.315919	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	451,470	451,470	1.532142	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	210,613	210,613	3.343464	0.000000	88.04
90.00	09000	CLINIC	1,000	828,592	829,592	0.947901	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	1,798,466	1,798,466	1.686434	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	258,986	258,986	1.360761	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	33,431	4,578,172	4,611,603	0.744502	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	11,269	233,928	245,197	1.171850	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,389,376	1,389,376	1.417899	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,148,959	72,047,957	106,196,916			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	34,148,959	72,047,957	106,196,916			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		88.01
88.02	08801	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
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	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	528,726	18,802,514	0.028120	5,537,406	155,712	50.00
53.00	05300 ANESTHESIOLOGY	0	3,092,552	0.000000	696,621	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	264,176	17,763,544	0.014872	412,580	6,136	54.00
60.00	06000 LABORATORY	152,282	14,895,466	0.010223	656,610	6,713	60.00
65.00	06500 RESPIRATORY THERAPY	50,234	2,852,128	0.017613	175,308	3,088	65.00
66.00	06600 PHYSICAL THERAPY	194,714	6,388,765	0.030478	613,462	18,697	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	103,983	3,203,721	0.032457	1,138,622	36,956	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	13,596	12,014,853	0.001132	5,789,728	6,554	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	40,511	10,963,011	0.003695	757,252	2,798	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	41,669	471,275	0.088418	0	0	88.00
88.01	08802 RURAL HEALTH CLINIC II	16,636	2,057,591	0.008085	0	0	88.01
88.02	08801 RURAL HEALTH CLINIC III	165,385	1,179,626	0.140201	0	0	88.02
88.03	08803 RURAL HEALTH CLINIC IV	4,761	451,470	0.010546	0	0	88.03
88.04	08804 RURAL HEALTH CLINIC V	4,525	210,613	0.021485	0	0	88.04
90.00	09000 CLINIC	89,761	829,592	0.108199	654	71	90.00
90.01	09001 ORTHOPAEDIC CLINIC	341,575	1,798,466	0.189926	0	0	90.01
90.02	09002 SURGICAL CLINIC	3,649	258,986	0.014090	0	0	90.02
90.03	09003 OP CLINIC	0	0	0.000000	0	0	90.03
91.00	09100 EMERGENCY	113,616	4,611,603	0.024637	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	33,157	245,197	0.135226	3,280	444	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	2,162,956	102,090,973		15,781,523	237,169	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1327		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/30/2020 1:51 pm	
			Title XVIII		Hospital		Cost	
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	323,442	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08801	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
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
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
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	323,442	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1327		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/30/2020 1:51 pm	
			Title XVIII		Hospital		Cost	
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	18,802,514	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	323,442	0	3,092,552	0.104587	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,763,544	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	14,895,466	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,852,128	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,388,765	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,203,721	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	12,014,853	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,963,011	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	471,275	0.000000	88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0	0	2,057,591	0.000000	88.01
88.02	08801	RURAL HEALTH CLINIC III	0	0	0	1,179,626	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	451,470	0.000000	88.03
88.04	08804	RURAL HEALTH CLINIC V	0	0	0	210,613	0.000000	88.04
90.00	09000	CLINIC	0	0	0	829,592	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	1,798,466	0.000000	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	258,986	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	4,611,603	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	245,197	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	323,442	0	102,090,973		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1327		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 3/30/2020 1:51 pm	
Cost Center Description				Title XVIII		Hospital		Cost	
				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	5,537,406	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY		0.000000	696,621	72,858	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	412,580	0	0	0	54.00
60.00	06000	LABORATORY		0.000000	656,610	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.000000	175,308	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	613,462	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000	1,138,622	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0.000000	5,789,728	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	757,252	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
88.01	08802	RURAL HEALTH CLINIC II		0.000000	0	0	0	0	88.01
88.02	08801	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
90.00	09000	CLINIC		0.000000	654	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC		0.000000	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC		0.000000	0	0	0	0	90.02
90.03	09003	OP CLINIC		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0.000000	3,280	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			15,781,523	72,858	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-1327		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 3/30/2020 1:51 pm	
			Title XVIII		Hospital		Cost	
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	0.173009	0	1,908,804	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.104587	0	424,621	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152423	0	6,400,802	0	0	54.00
60.00	06000	LABORATORY	0.157103	0	5,521,538	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.431145	0	963,522	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.363473	0	1,728,645	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509173	0	275,991	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.267464	0	224,386	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.353267	0	5,191,846	2,390	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08801	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
90.00	09000	CLINIC	0.947901	0	380,693	611	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.686434	0	653,186	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.360761	0	93,214	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.744502	0	1,496,591	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.171850	0	121,436	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1.417899		0			95.00
200.00		Subtotal (see instructions)		0	25,385,275	3,001	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	25,385,275	3,001	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1327		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 3/30/2020 1:51 pm	
				Title XVIII		Hospital		Cost	
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	330,240	0					50.00
53.00	05300	ANESTHESIOLOGY	44,410	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	975,629	0					54.00
60.00	06000	LABORATORY	867,450	0					60.00
65.00	06500	RESPIRATORY THERAPY	415,418	0					65.00
66.00	06600	PHYSICAL THERAPY	628,316	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,527	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	60,015	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,834,108	844					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
88.01	08802	RURAL HEALTH CLINIC II	0	0					88.01
88.02	08801	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
90.00	09000	CLINIC	360,859	579					90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,101,555	0					90.01
90.02	09002	SURGICAL CLINIC	126,842	0					90.02
90.03	09003	OP CLINIC	0	0					90.03
91.00	09100	EMERGENCY	1,114,215	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	142,305	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	8,141,889	1,423					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	8,141,889	1,423					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:

Worksheet D

Component CCN: 14-Z327

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
3/30/2020 1:51 pm

			Title XVIII	Swing Beds - SNF	Cost		
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	0.173009	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.104587	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152423	0	0	0	54.00
60.00	06000	LABORATORY	0.157103	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.431145	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.363473	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509173	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.267464	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.353267	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000			0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000			0	88.01
88.02	08801	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
90.00	09000	CLINIC	0.947901	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.686434	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.360761	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	90.03
91.00	09100	EMERGENCY	0.744502	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.171850	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1.417899		0		95.00
200.00		Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1327

Period:

Worksheet D

Component CCN: 14-Z327

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
3/30/2020 1:51 pm

			Title XVIII		Swing Beds - SNF		Cost	
	Cost Center Description		Costs					
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
			6.00	7.00				
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0			50.00	
53.00	05300	ANESTHESIOLOGY	0	0			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00	
60.00	06000	LABORATORY	0	0			60.00	
65.00	06500	RESPIRATORY THERAPY	0	0			65.00	
66.00	06600	PHYSICAL THERAPY	0	0			66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0			73.00	
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0			88.00	
88.01	08802	RURAL HEALTH CLINIC II	0	0			88.01	
88.02	08801	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	
90.00	09000	CLINIC	0	0			90.00	
90.01	09001	ORTHOPAEDIC CLINIC	0	0			90.01	
90.02	09002	SURGICAL CLINIC	0	0			90.02	
90.03	09003	OP CLINIC	0	0			90.03	
91.00	09100	EMERGENCY	0	0			91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0				95.00	
200.00		Subtotal (see instructions)	0	0			200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0				201.00	
202.00		Net Charges (line 200 - line 201)	0	0			202.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1327

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

Worksheet D-1

Date/Time Prepared:
3/30/2020 1:51 pm

Title XVIII		Hospital	Cost
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)	2,856	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,429	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,215	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	427	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,220	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)	291	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,834,688	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)	573,324	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,261,364	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,261,364	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)	1,342.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,638,070	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,638,070	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1327

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

Worksheet D-1

Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		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	527,649	54	9,771.28	18	175,883	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)					3,895,757	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,709,710	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					390,720	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)					390,720	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)					214	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,342.68	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					287,334	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1327

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

Worksheet D-1

Date/Time Prepared:
3/30/2020 1:51 pm

		Title XVIII		Hospital	Cost	
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	442,507	3,834,688	0.115396	287,334	33,157
91.00	Nursing School cost	0	3,834,688	0.000000	287,334	0
92.00	Allied health cost	0	3,834,688	0.000000	287,334	0
93.00	All other Medical Education	0	3,834,688	0.000000	287,334	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1327	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/30/2020 1:51 pm	
Cost Center Description			Title XVIII	Hospital	Cost	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		1,681,206		30.00
31.00	03100	INTENSIVE CARE UNIT		43,115		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.173009	5,537,406	958,021	50.00
53.00	05300	ANESTHESIOLOGY	0.104587	696,621	72,858	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152423	412,580	62,887	54.00
60.00	06000	LABORATORY	0.157103	656,610	103,155	60.00
65.00	06500	RESPIRATORY THERAPY	0.431145	175,308	75,583	65.00
66.00	06600	PHYSICAL THERAPY	0.363473	613,462	222,977	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509173	1,138,622	579,756	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.267464	5,789,728	1,548,544	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.353267	757,252	267,512	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801	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
90.00	09000	CLINIC	0.947901	654	620	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.686434	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.360761	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.744502	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.171850	3,280	3,844	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		15,781,523	3,895,757	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)		15,781,523		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1327 Component CCN: 14-Z327	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 3/30/2020 1:51 pm	
Cost Center Description			Title XVIII	Swing Beds - SNF	Cost	
			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
31.00	03100	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.173009	193	33	50.00
53.00	05300	ANESTHESIOLOGY	0.104587	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152423	29,680	4,524	54.00
60.00	06000	LABORATORY	0.157103	68,415	10,748	60.00
65.00	06500	RESPIRATORY THERAPY	0.431145	33,695	14,527	65.00
66.00	06600	PHYSICAL THERAPY	0.363473	188,071	68,359	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.509173	54,876	27,941	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.267464	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.353267	116,778	41,254	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08802	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08801	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
90.00	09000	CLINIC	0.947901	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.686434	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.360761	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.744502	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.171850	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		491,708	167,386	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		491,708		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1327	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 3/30/2020 1:51 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,143,312	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		8,143,312	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 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)		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)		8,224,745	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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		77,242	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,964,622	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)		4,182,881	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)		4,182,881	30.00
31.00	Primary payer payments		298	31.00
32.00	Subtotal (line 30 minus line 31)		4,182,583	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)		497,966	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		323,678	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		466,486	36.00
37.00	Subtotal (see instructions)		4,506,261	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,506,261	40.00
40.01	Sequestration adjustment (see instructions)		90,125	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,953,841	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-537,705	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		232,906	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: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
3/30/2020 1:51 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,073,684		4,386,320	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	12/11/2019	24,109	12/11/2019	129,407	3.01
3.02		08/07/2019	143,165	08/07/2019	438,114	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)		167,274		567,521	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,240,958		4,953,841	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		18,240		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		537,705	6.02
7.00	Total Medicare program liability (see instructions)		5,259,198		4,416,136	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: 14-1327

Period:

Worksheet E-1

Component CCN: 14-Z327

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
3/30/2020 1:51 pm

		Title XVIII		Swing Beds - SNF		Cost
		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		570,071		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	12/11/2019	1,551		0	3.01
3.02		08/07/2019	5,895		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)		7,446		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)		577,517		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		36,800		0	6.02
7.00	Total Medicare program liability (see instructions)		540,717		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: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
3/30/2020 1:51 pm

		Title XVIII	Hospital	Cost
				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: 14-1327

Period:

Worksheet E-2

Component CCN: 14-Z327

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

		Title XVIII	Swing Beds - SNF	Cost	
			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)		394,627	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)		169,060	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		291	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)		563,687	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		563,687	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)		563,687	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		11,935	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		551,752	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)		551,752	0	19.00
19.01	Sequestration adjustment (see instructions)		11,035	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		577,517	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)		-36,800	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: 14-1327	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 3/30/2020 1:51 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		5,709,710	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		5,709,710	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		5,766,807	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		5,766,807	19.00
20.00	Deductibles (exclude professional component)		444,640	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		5,322,167	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		5,322,167	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		68,249	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		44,362	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		68,118	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		5,366,529	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		5,366,529	30.00
30.01	Sequestration adjustment (see instructions)		107,331	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		5,240,958	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		18,240	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		63,068	34.00

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

Provider CCN: 14-1327

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

Worksheet G

Date/Time Prepared:
3/30/2020 1:51 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,443,943	0	0	0	1.00
2.00	Temporary investments	9,011,563	0	0	0	2.00
3.00	Notes receivable	204,751	0	0	0	3.00
4.00	Accounts receivable	21,305,972	0	0	0	4.00
5.00	Other receivable	18,729	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,815,097	0	0	0	6.00
7.00	Inventory	889,574	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	865,095	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)	26,924,530	0	0	0	11.00
FIXED ASSETS						
12.00	Land	546,914	0	0	0	12.00
13.00	Land improvements	2,101,828	0	0	0	13.00
14.00	Accumulated depreciation	-1,261,793	0	0	0	14.00
15.00	Buildings	27,542,055	0	0	0	15.00
16.00	Accumulated depreciation	-12,031,024	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-2,883,214	0	0	0	18.00
19.00	Fixed equipment	4,919,416	0	0	0	19.00
20.00	Accumulated depreciation	-13,246,667	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	16,019,906	0	0	0	23.00
24.00	Accumulated depreciation	1,301,576	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,008,997	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,933,527	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,734,589	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,078,736	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,659,723	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	552,151	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,025,199	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,890,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,890,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,915,199	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	38,018,328				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)	38,018,328	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,933,527	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1327

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

Worksheet G-1

Date/Time Prepared:
3/30/2020 1:51 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		32,827,829		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,190,999				2.00
3.00	Total (sum of line 1 and line 2)		38,018,828		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)		38,018,828		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)		38,018,828		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: 14-1327

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
3/30/2020 1:51 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,596,899		3,596,899	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,596,899		3,596,899	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	84,946		84,946	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)	84,946		84,946	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,681,845		3,681,845	17.00
18.00	Ancillary services	32,510,589	74,804,190	107,314,779	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	472,574	472,574	20.00
20.01	RURAL HEALTH CLINIC II	0	2,296,963	2,296,963	20.01
20.02	RURAL HEALTH CLINIC III	0	1,193,118	1,193,118	20.02
20.03	RURAL HEALTH CLINIC IV	0	451,788	451,788	20.03
20.04	RURAL HEALTH CLINIC V	0	837,865	837,865	20.04
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,150,594	2,150,594	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	801,750	801,750	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	36,192,434	83,008,842	119,201,276	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,986,439		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		48,986,439		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1327

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

Worksheet G-3

Date/Time Prepared:
3/30/2020 1:51 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	119,201,276	1.00
2.00	Less contractual allowances and discounts on patients' accounts	66,922,644	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,278,632	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,986,439	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,292,193	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	20,028	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	139,746	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	14,705	16.00
17.00	Revenue from sale of drugs to other than patients	480,090	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	456,467	24.00
25.00	Total other income (sum of lines 6-24)	1,111,036	25.00
26.00	Total (line 5 plus line 25)	4,403,229	26.00
27.00	NON-OPERATING G/L	-787,770	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-787,770	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,190,999	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8501

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	7,943	7,943
3.00	Nurse Practitioner	0	0	0	286	286
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	19,351	19,351
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	98,696	98,696
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	126,276	126,276
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	10,846	10,846	0	10,846
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	10,846	10,846	0	10,846
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	10,846	10,846	126,276	137,122
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	150	150	0	150
30.00	Administrative Costs	98,696	160,388	259,084	-126,246	132,838
31.00	Total Facility Overhead (sum of lines 29 and 30)	98,696	160,538	259,234	-126,246	132,988
32.00	Total facility costs (sum of lines 22, 28 and 31)	98,696	171,384	270,080	30	270,110

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8501

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0	1.00	
2.00	Physician Assistant	0	7,943	2.00	
3.00	Nurse Practitioner	0	286	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	19,351	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	98,696	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	126,276	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	12.00	
13.00	Other Costs Under Agreement	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00	
15.00	Medical Supplies	0	10,846	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	10,846	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	137,122	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	150	29.00	
30.00	Administrative Costs	0	132,838	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	132,988	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	270,110	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8568

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

3/30/2020 1:51 pm

				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	784,005	784,005	1.00
2.00	Physician Assistant	0	0	0	103,409	103,409	2.00
3.00	Nurse Practitioner	0	0	0	83,660	83,660	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	343,399	343,399	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	55,796	55,796	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	1,370,269	1,370,269	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	213,245	213,245	0	213,245	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						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	213,245	213,245	0	213,245	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	213,245	213,245	1,370,269	1,583,514	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	17,388	17,388	0	17,388	29.00
30.00	Administrative Costs	1,723,365	64,163	1,787,528	-1,395,088	392,440	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,723,365	81,551	1,804,916	-1,395,088	409,828	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,723,365	294,796	2,018,161	-24,819	1,993,342	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8568

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	784,005		1.00
2.00	Physician Assistant	0	103,409		2.00
3.00	Nurse Practitioner	0	83,660		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	343,399		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	55,796		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,370,269		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	213,245		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	213,245		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,583,514		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	17,388		29.00
30.00	Administrative Costs	0	392,440		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	409,828		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,993,342		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8579

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				RHC III		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	480,863	480,863	1.00
2.00	Physician Assistant	0	0	0	89,595	89,595	2.00
3.00	Nurse Practitioner	0	0	0	757	757	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	59,421	59,421	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	35,824	35,824	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	666,460	666,460	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	50,307	50,307	0	50,307	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	50,307	50,307	0	50,307	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	50,307	50,307	666,460	716,767	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	3,230	3,230	0	3,230	29.00
30.00	Administrative Costs	802,114	21,733	823,847	-667,149	156,698	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	802,114	24,963	827,077	-667,149	159,928	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	802,114	75,270	877,384	-689	876,695	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8579

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				RHC III	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	480,863	1.00	
2.00	Physician Assistant	0	89,595	2.00	
3.00	Nurse Practitioner	0	757	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	59,421	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	35,824	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	666,460	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	50,307	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	50,307	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	716,767	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	3,230	29.00	
30.00	Administrative Costs	0	156,698	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	159,928	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	876,695	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8599

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

						RHC IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification 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	234,413	234,413	1.00		
2.00	Physician Assistant	0	0	0	49,550	49,550	2.00		
3.00	Nurse Practitioner	0	0	0	0	0	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	59,806	59,806	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00		
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	343,769	343,769	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	34,032	34,032	0	34,032	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						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	34,032	34,032	0	34,032	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	34,032	34,032	343,769	377,801	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	4,857	4,857	0	4,857	29.00		
30.00	Administrative Costs	410,094	1,686	411,780	-343,769	68,011	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	410,094	6,543	416,637	-343,769	72,868	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	410,094	40,575	450,669	0	450,669	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8599

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC IV	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	234,413		1.00
2.00	Physician Assistant	0	49,550		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	59,806		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	343,769		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	34,032		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	34,032		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	377,801		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	4,857		29.00
30.00	Administrative Costs	0	68,011		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	72,868		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	450,669		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8601

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

						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	0	0	0	25,339	25,339	1.00		
2.00	Physician Assistant	0	0	0	30	30	2.00		
3.00	Nurse Practitioner	0	0	0	121,176	121,176	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	145,402	145,402	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00		
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	291,947	291,947	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	68,632	68,632	0	68,632	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						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	68,632	68,632	0	68,632	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	68,632	68,632	291,947	360,579	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	27,260	27,260	0	27,260	29.00		
30.00	Administrative Costs	349,606	3,520	353,126	-266,469	86,657	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	349,606	30,780	380,386	-266,469	113,917	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	349,606	99,412	449,018	25,478	474,496	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1327

Period:

Worksheet M-1

Component CCN: 14-8601

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				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	25,339		1.00
2.00	Physician Assistant	0	30		2.00
3.00	Nurse Practitioner	0	121,176		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	145,402		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	291,947		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	68,632		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	68,632		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	360,579		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	27,260		29.00
30.00	Administrative Costs	0	86,657		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	113,917		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	474,496		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1327 Component CCN: 14-8501		Period: From 01/01/2019 To 12/31/2019		Worksheet M-2 Date/Time Prepared: 3/30/2020 1:51 pm	
			RHC I		Cost			
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4			
	1.00	2.00	3.00	4.00	5.00			
VISITS AND PRODUCTIVITY								
Positions								
1.00	Physician	0.00	0	4,200	0			1.00
2.00	Physician Assistant	0.47	2,311	2,100	987			2.00
3.00	Nurse Practitioner	0.31	1,522	2,100	651			3.00
4.00	Subtotal (sum of lines 1 through 3)	0.78	3,833		1,638		3,833	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)	0.78	3,833				3,833	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)						137,122	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)						137,122	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)						1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)						132,988	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						211,745	15.00
16.00	Total overhead (sum of lines 14 and 15)						344,733	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						344,733	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						344,733	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						481,855	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8568

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.77	9,613	4,200	11,634		1.00
2.00	Physician Assistant	1.15	1,470	2,100	2,415		2.00
3.00	Nurse Practitioner	0.93	1,730	2,100	1,953		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.85	12,813		16,002	16,002	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.85	12,813			16,002	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)					1,583,514	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,583,514	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					409,828	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					937,608	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,347,436	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,347,436	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,347,436	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,930,950	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8579

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.91	4,853	4,200	3,822		1.00
2.00	Physician Assistant	0.89	3,178	2,100	1,869		2.00
3.00	Nurse Practitioner	0.01	105	2,100	21		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.81	8,136		5,712	8,136	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)	1.81	8,136			8,136	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)					716,767	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					716,767	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					159,928	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					675,597	15.00
16.00	Total overhead (sum of lines 14 and 15)					835,525	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					835,525	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					835,525	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,552,292	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8599

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				RHC IV		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.49	1,773	2,117	1,037		1.00
2.00	Physician Assistant	0.43	2,108	1,059	455		2.00
3.00	Nurse Practitioner	0.00	0	1,059	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.92	3,881		1,492	3,881	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)	0.92	3,881			3,881	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)					377,801	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					377,801	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					72,868	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					241,047	15.00
16.00	Total overhead (sum of lines 14 and 15)					313,915	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					313,915	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					313,915	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					691,716	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1327

Period:

Worksheet M-2

Component CCN: 14-8601

From 01/01/2019
To 12/31/2019Date/Time Prepared:
3/30/2020 1:51 pm

				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	0.08	518	2,543	203		1.00
2.00	Physician Assistant	0.01	1	1,272	13		2.00
3.00	Nurse Practitioner	0.39	1,536	1,272	496		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.48	2,055		712	2,055	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)	0.48	2,055			2,055	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)					360,579	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					360,579	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					113,917	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					229,681	15.00
16.00	Total overhead (sum of lines 14 and 15)					343,598	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					343,598	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					343,598	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					704,177	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 3/30/2020 1:51 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			481,855	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)			481,855	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,833	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)			3,833	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			125.71	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		125.71	125.71	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	310	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	38,970	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	38,970	16.00
16.01	Total program charges (see instructions)(from contractor's records)			40,949	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			25,589	16.04
16.05	Total program cost (see instructions)		0	25,589	16.05
17.00	Primary payer amounts			20	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			6,984	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			6,792	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			25,569	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)			25,569	22.00
23.00	Allowable bad debts (see instructions)			146	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			95	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			52	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)			25,664	26.00
26.01	Sequestration adjustment (see instructions)			513	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			16,398	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)			8,753	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: 14-1327 Component CCN: 14-8568	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 3/30/2020 1:51 pm		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,930,950	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			18,065	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,912,885	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,002	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)			16,002	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			182.03	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			182.03	182.03	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	2,011	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	366,062	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	366,062	16.00
16.01	Total program charges (see instructions)(from contractor's records)				316,201	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16,967	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				19,643	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.)				252,593	16.04
16.05	Total program cost (see instructions)			0	272,236	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				30,678	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				53,710	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				272,236	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				16,490	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				288,726	22.00
23.00	Allowable bad debts (see instructions)				978	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				636	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)				289,362	26.00
26.01	Sequestration adjustment (see instructions)				5,787	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				296,461	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)				-12,886	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: 14-1327 Component CCN: 14-8579	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 3/30/2020 1:51 pm		
		Title XVIII	RHC III	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,552,292	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			73,720	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,478,572	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,136	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)			8,136	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			181.73	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			181.73	181.73	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	4,470	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	812,333	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	812,333	16.00
16.01	Total program charges (see instructions)(from contractor's records)				630,440	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				6,147	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				7,920	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.)				600,886	16.04
16.05	Total program cost (see instructions)			0	608,806	16.05
17.00	Primary payer amounts				6	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				53,306	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				114,193	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				608,800	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				48,945	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				657,745	22.00
23.00	Allowable bad debts (see instructions)				1,213	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				788	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				295	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)				658,533	26.00
26.01	Sequestration adjustment (see instructions)				13,171	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				478,961	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)				166,401	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		WABASH GENERAL HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1327	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3	
		Component CCN: 14-8599		Date/Time Prepared: 3/30/2020 1:51 pm	
		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)			691,716	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			22,329	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			669,387	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,881	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)			3,881	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			172.48	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		172.48	172.48	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,208	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	208,356	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	208,356	16.00
16.01	Total program charges (see instructions)(from contractor's records)			158,155	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			5,069	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			6,678	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.)			156,310	16.04
16.05	Total program cost (see instructions)		0	162,988	16.05
17.00	Primary payer amounts			20	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			6,291	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			29,358	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			162,968	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			19,749	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			182,717	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)			182,717	26.00
26.01	Sequestration adjustment (see instructions)			3,654	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			42,060	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)			137,003	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: 14-1327 Component CCN: 14-8601	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 3/30/2020 1:51 pm		
		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)			704,177	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			3,753	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			700,424	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,055	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)			2,055	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			340.84	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)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			340.84	340.84	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	258	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	87,937	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	87,937	16.00
16.01	Total program charges (see instructions)(from contractor's records)				44,250	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				1,880	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				3,736	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.)				67,050	16.04
16.05	Total program cost (see instructions)			0	70,786	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				389	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				8,396	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				70,786	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				3,633	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				74,419	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)				74,419	26.00
26.01	Sequestration adjustment (see instructions)				1,488	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				9,895	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)				63,036	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: 14-1327 Component CCN: 14-8568	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/30/2020 1:51 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,370,269	1,370,269	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000628	0.001256	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		861	1,721	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		6,216	962	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		7,077	2,683	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,583,514	1,583,514	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,347,436	1,347,436	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.004469	0.001694	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		6,022	2,283	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		13,099	4,966	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		38	76	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		344.71	65.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		34	73	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		11,720	4,770	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)			18,065	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)			16,490	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1327 Component CCN: 14-8579	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/30/2020 1:51 pm	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		666,460	666,460	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.003541	0.019522	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,360	13,011	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		13,086	5,583	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		15,446	18,594	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		716,767	716,767	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		835,525	835,525	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.021550	0.025941	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		18,006	21,674	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		33,452	40,268	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		80	441	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		418.15	91.31	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		57	275	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		23,835	25,110	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)			73,720	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			48,945	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1327 Component CCN: 14-8599	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/30/2020 1:51 pm	
		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)		343,769	343,769	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001654	0.017416	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		569	5,987	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		3,108	2,532	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		3,677	8,519	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		377,801	377,801	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		313,915	313,915	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.009733	0.022549	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		3,055	7,078	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		6,732	15,597	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		19	200	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		354.32	77.99	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		17	176	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		6,023	13,726	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)			22,329	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)			19,749	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1327 Component CCN: 14-8601	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 3/30/2020 1:51 pm	
		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)		291,947	291,947	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000835	0.002338	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		244	683	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		818	177	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,062	860	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		360,579	360,579	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		343,598	343,598	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.002945	0.002385	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,012	819	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,074	1,679	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		5	14	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		414.80	119.93	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		5	13	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,074	1,559	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)			3,753	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			3,633	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1327 Component CCN: 14-8501	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/30/2020 1:51 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		14,828	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01		08/07/2019	1,225	3.01	
3.02		12/11/2019	345	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)		1,570	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		16,398	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		8,753	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		25,151	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: 14-1327 Component CCN: 14-8568	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/30/2020 1:51 pm	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			368,929	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			08/07/2019	58,147	3.50
3.51			12/11/2019	14,321	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)			-72,468	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			296,461	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			12,886	6.02
7.00	Total Medicare program liability (see instructions)			283,575	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: 14-1327 Component CCN: 14-8579	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/30/2020 1:51 pm	
		RHC III		Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		665,858	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		08/07/2019	150,554	3.50	
3.51		12/11/2019	36,343	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)		-186,897	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		478,961	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		166,401	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		645,362	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: 14-1327 Component CCN: 14-8599	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/30/2020 1:51 pm	
			RHC IV	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			42,060	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			42,060	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			137,003	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			179,063	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: 14-1327 Component CCN: 14-8601	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 3/30/2020 1:51 pm	
			RHC V	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			9,895	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)			9,895	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			63,036	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			72,931	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00