

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: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 5/19/2020 10:18 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 5/19/2020	Time: 10:18 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PANA COMMUNITY HOSPITAL (14-1341) 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) JAMES MOON

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
	1.00	2.00	3.00	4.00	5.00		
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	8,914	319,233	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	11,194	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0			0	9.00
10.00	RURAL HEALTH CLINIC I	0		15,517		0	10.00
200.00	Total	0	20,108	334,750	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: 14-1341		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/19/2020 10:18 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 101 E. 9TH STREET			PO Box:				1.00			
2.00	City: PANA			State: IL		Zip Code: 62557-1716		County: CHRISTIAN			
		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		PANA COMMUNITY HOSPITAL	141341	99914	1	11/01/2004	N	O	N	
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF		PANA COMMUNITY HOSPITAL	142341	99914		04/06/2004	N	O	N	
8.00	Swing Beds - NF										
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTG										
12.00	Hospital-Based HHA		QUAD COUNTY HOME HEALTH AGENCY	147299	99914		01/01/1985	N	P	N	
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice		PCH HOSPICE	141575	99914		08/31/1994				
15.00	Hospital-Based Health Clinic - RHC		COMMUNITY MEDICAL CLINIC PANA	148508	99914		03/18/2010	N	O	N	
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) I										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019		12/31/2019		20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00		3.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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			22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00	
				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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1341		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/19/2020 10:18 am	
				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
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr	
							1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.							2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.							2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0	35.00
							Beginning:	Ending:	
							1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							0	37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
							Y/N	Y/N	
							1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)							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	40.00
							V	XVIII	XIX
							1.00	2.00	3.00
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)							N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.							N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.							N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.							N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.							N	56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							N	58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.							N	59.00
						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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
5/19/2020 10:18 am

	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	61.00
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

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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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)		Y		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	
			1.00	2.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 5/19/2020 10:18 am	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	91,234	0	0	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1341		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 5/19/2020 10:18 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		12/16/2019	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.							Y	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		N	
156.00	Subprovider - IPF	N		N		N		N	
157.00	Subprovider - IRF	N		N		N		N	
158.00	SUBPROVIDER								
159.00	SNF	N		N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							N	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)							Y	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: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 5/19/2020 10:18 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/29/2020	Y	03/29/2020
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
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: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
5/19/2020 10:18 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		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.		Y		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		Y		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1341

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.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
5/19/2020 10:18 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	28,536.00	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)		22	8,030	28,536.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		22	8,030	28,536.00	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				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: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
5/19/2020 10:18 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	856	13	1,189			1.00
2.00	HMO and other (see instructions)	0	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	482	0	522			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	11			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,338	13	1,722			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)	1,338	13	1,722	0.00	156.32	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	5,677	0	8,591	0.00	15.45	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	7.75	24.00
24.10	HOSPICE (non-distinct part)			34			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	3,091	0	13,351	0.00	21.32	26.00
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	200.84	27.00
28.00	Observation Bed Days		0	73			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
5/19/2020 10:18 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	278	5	418	1.00
2.00 HMO and other (see instructions)			0	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	278	5	418	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-1341 Component CCN: 14-7299		Period: From 01/01/2019 To 12/31/2019		Worksheet S-4 Date/Time Prepared: 5/19/2020 10:18 am	
				Home Health Agency I		PPS	
				1.00			
0.00 County				CHRISTIAN		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	196	29	27	252	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	306.00	58.00	133.00	497.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			1.52	0.00	1.52	5.00
6.00	Direct Nursing Service			6.96	0.00	6.96	6.00
7.00	Nursing Supervisor			0.65	0.00	0.65	7.00
8.00	Physical Therapy Service			1.91	0.00	1.91	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.60	0.00	0.60	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.10	0.00	0.10	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.53	0.00	0.53	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.12	0.00	0.12	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	DME			2.06	0.00	2.06	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
20.01				41180			20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	2,065	30	78	38	2,211	21.00
22.00	Skilled Nursing Visit Charges	412,360	6,180	15,873	7,720	442,133	22.00
23.00	Physical Therapy Visits	2,346	23	33	31	2,433	23.00
24.00	Physical Therapy Visit Charges	503,145	4,945	4,290	6,665	519,045	24.00
25.00	Occupational Therapy Visits	873	22	9	2	906	25.00
26.00	Occupational Therapy Visit Charges	201,366	5,082	1,155	462	208,065	26.00
27.00	Speech Pathology Visits	59	15	2	11	87	27.00
28.00	Speech Pathology Visit Charges	13,629	3,465	462	2,541	20,097	28.00
29.00	Medical Social Service Visits	13	1	0	0	14	29.00
30.00	Medical Social Service Visit Charges	3,432	267	0	0	3,699	30.00
31.00	Home Health Aide Visits	26	0	0	0	26	31.00
32.00	Home Health Aide Visit Charges	3,324	0	0	0	3,324	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,382	91	122	82	5,677	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,137,256	19,939	21,780	17,388	1,196,363	35.00
36.00	Total Number of Episodes (standard/non outlier)	344		32	6	382	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	9,382	712	307	411	10,812	38.00

Health Financial Systems		PANA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1341 Component CCN: 14-8508		Period: From 01/01/2019 To 12/31/2019 Worksheet S-8 Date/Time Prepared: 5/19/2020 10:18 am		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification	101 E. 9TH STREET, SUITE 105				1.00
	Street	City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	PANA	IL	62557	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	
		1.00	2.00	3.00	4.00	
	Facility hours of operations (1)					
11.00	CLINIC	08:30	20:00	08:30	11.00	
		1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y		3	13.00	
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number	COMMUNITY MEDICAL CLINIC		148508	14.00	
14.01		PANA				
14.02		COMMUNITY MEDICAL CLINIC OF ASSUMPTI		148575	14.01	
		COMMUNITY MEDICAL CLINIC OF NOKOMIS		148574	14.02	
		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	CHRISTIAN			2.00	

MCRIF32 - 15.13.167.1

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-1341

Period:

Worksheet S-9

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019PARTS I THROUGH IV
Date/Time Prepared:
5/19/2020 10:18 am

		Hospice I					
		Unduplicated Days					
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)
		1.00	2.00	3.00	4.00	5.00	6.00
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	7,181	431	575	8,187	11.00
12.00	Hospice Inpatient Respite Care	28	2	0	30	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	7,209	433	575	8,217	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 5/19/2020 10:18 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.432090 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	1,773,002		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,157,981		5.00
6.00	Medicaid charges	8,588,818		6.00
7.00	Medicaid cost (line 1 times line 6)	3,711,142		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)	36,890	9,464	46,354 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	15,940	9,464	25,404 21.00
22.00	Payments received from patients for amounts previously written off as charity care	18,445	4,732	23,177 22.00
23.00	Cost of charity care (line 21 minus line 22)	0	4,732	4,732 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,602,003		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	298,820		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	459,724		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,142,279		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	654,471		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	659,203		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	659,203		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES					Provider CCN: 14-1341		Period: From 01/01/2019 To 12/31/2019		Worksheet A Date/Time Prepared: 5/19/2020 10:18 am	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)			
			1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,221,954	1,221,954	-670,513	551,441	1.00		
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX		102,128	102,128	716,276	818,404	1.01		
2.00	00200	CAP REL COSTS-MVBLE EQUIP		462,123	462,123	13,514	475,637	2.00		
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,206,409	2,206,409	-18,413	2,187,996	4.00		
5.01	00540	NONPATIENT TELEPHONES	0	0	0	164,916	164,916	5.01		
5.02	00550	DATA PROCESSING	336,684	471,232	807,916	-130,596	677,320	5.02		
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	393,203	386,108	779,311	-33,751	745,560	5.03		
5.04	00590	OTHER ADMIN AND GENERAL	806,294	1,326,186	2,132,480	54,786	2,187,266	5.04		
7.00	00700	OPERATION OF PLANT	244,208	484,715	728,923	0	728,923	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	56,778	56,778	8.00		
9.00	00900	HOUSEKEEPING	279,699	89,926	369,625	-56,778	312,847	9.00		
10.00	01000	DIETARY	208,426	218,411	426,837	-353,304	73,533	10.00		
11.00	01100	CAFETERIA	0	0	0	149,557	149,557	11.00		
13.00	01300	NURSING ADMINISTRATION	330,883	7,602	338,485	0	338,485	13.00		
14.00	01400	CENTRAL SERVICES & SUPPLY	36,595	43,449	80,044	0	80,044	14.00		
15.00	01500	PHARMACY	256,685	1,056,736	1,313,421	-883,138	430,283	15.00		
16.00	01600	MEDICAL RECORDS & LIBRARY	158,858	118,065	276,923	0	276,923	16.00		
17.00	01700	SOCIAL SERVICE	59,748	7,596	67,344	0	67,344	17.00		
19.00	01900	NONPHYSICIAN ANESTHETISTS	240,698	0	240,698	18,413	259,111	19.00		
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	1,045,188	260,927	1,306,115	0	1,306,115	30.00		
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	435,134	521,115	956,249	0	956,249	50.00		
53.00	05300	ANESTHESIOLOGY	0	22,183	22,183	0	22,183	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	499,731	855,993	1,355,724	0	1,355,724	54.00		
60.00	06000	LABORATORY	616,567	438,608	1,055,175	0	1,055,175	60.00		
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00		
65.00	06500	RESPIRATORY THERAPY	529,071	159,515	688,586	0	688,586	65.00		
66.00	06600	PHYSICAL THERAPY	618,966	77,559	696,525	0	696,525	66.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,303	32,303	0	32,303	71.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	883,138	883,138	73.00		
OUTPATIENT SERVICE COST CENTERS										
88.00	08800	RURAL HEALTH CLINIC	1,686,281	560,474	2,246,755	2,447	2,249,202	88.00		
91.00	09100	EMERGENCY	857,229	1,913,442	2,770,671	0	2,770,671	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00		
OTHER REIMBURSABLE COST CENTERS										
101.00	10100	HOME HEALTH AGENCY	815,120	261,214	1,076,334	0	1,076,334	101.00		
SPECIAL PURPOSE COST CENTERS										
116.00	11600	HOSPICE	345,902	294,338	640,240	0	640,240	116.00		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,801,170	13,600,311	24,401,481	-86,668	24,314,813	118.00		
NONREIMBURSABLE COST CENTERS										
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,265,011	453,812	1,718,823	-569	1,718,254	192.00		
194.00	07950	HOMEBOUND MEALS	0	0	0	87,237	87,237	194.00		
194.01	07951	FITNESS WELLNESS PROGRAM	107,817	34,466	142,283	0	142,283	194.01		
194.02	07952	FOUNDATION	46,744	2,946	49,690	0	49,690	194.02		
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03		
200.00		TOTAL (SUM OF LINES 118 through 199)	12,220,742	14,091,535	26,312,277	0	26,312,277	200.00		

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1341

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

Worksheet A

Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	551,441	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	-102,128	716,276	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-87	475,550	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-363,343	1,824,653	4.00
5.01	00540	NONPATIENT TELEPHONES	-6,539	158,377	5.01
5.02	00550	DATA PROCESSING	0	677,320	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	745,560	5.03
5.04	00590	OTHER ADMIN AND GENERAL	-600,134	1,587,132	5.04
7.00	00700	OPERATION OF PLANT	-3,384	725,539	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,778	8.00
9.00	00900	HOUSEKEEPING	0	312,847	9.00
10.00	01000	DIETARY	-2,124	71,409	10.00
11.00	01100	CAFETERIA	-31,792	117,765	11.00
13.00	01300	NURSING ADMINISTRATION	0	338,485	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,044	14.00
15.00	01500	PHARMACY	-62,398	367,885	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-30,465	246,458	16.00
17.00	01700	SOCIAL SERVICE	0	67,344	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	259,111	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-346,220	959,895	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-269,088	687,161	50.00
53.00	05300	ANESTHESIOLOGY	0	22,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,355,724	54.00
60.00	06000	LABORATORY	-1,116	1,054,059	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-55,830	632,756	65.00
66.00	06600	PHYSICAL THERAPY	-3,770	692,755	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	32,303	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	883,138	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-5,351	2,243,851	88.00
91.00	09100	EMERGENCY	-924,556	1,846,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,076,334	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	38,671	678,911	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,769,654	21,545,159	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,718,254	192.00
194.00	07950	HOMEBOUND MEALS	0	87,237	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	142,283	194.01
194.02	07952	FOUNDATION	0	49,690	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,769,654	23,542,623	200.00

RECLASSIFICATIONS

Provider CCN: 14-1341

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

Worksheet A-6

Date/Time Prepared:
5/19/2020 10:18 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DIETARY COSTS					
1.00	CAFETERIA	11.00	73,029	76,528	1.00	
2.00	OTHER ADMIN AND GENERAL	5.04	56,892	59,618	2.00	
3.00	HOMEBOUND MEALS	194.00	42,598	44,639	3.00	
	0		172,519	180,785		
	B - CRNAS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	18,413	1.00	
	0		0	18,413		
	C - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	59,277	1.00	
	0		0	59,277		
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	56,778	1.00	
	0		0	56,778		
	E - TELEPHONE AND POSTAGE					
1.00	NONPATIENT TELEPHONES	5.01	34,320	130,596	1.00	
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03		569	2.00	
3.00	0	0.00	0	0	3.00	
			34,320	131,165		
	G - RHC PHYSICIAN RECRUITMENT					
1.00	RURAL HEALTH CLINIC	88.00	0	2,447	1.00	
	0		0	2,447		
	I - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.01	0	690,471	1.00	
	NEW BDG EX					
	TOTALS		0	690,471		
	J - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	883,138	1.00	
	TOTALS		0	883,138		
500.00	Grand Total: Increases		206,839	2,022,474	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1341

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

Worksheet A-6

Date/Time Prepared:
5/19/2020 10:18 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - DIETARY COSTS						
1.00	DIETARY	10.00	172,519	180,785	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		172,519	180,785		
B - CRNAS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18,413	0	1.00
	0		0	18,413		
C - PROPERTY INSURANCE						
1.00	OTHER ADMIN AND GENERAL	5.04	0	59,277	12	1.00
	0		0	59,277		
D - LAUNDRY						
1.00	HOUSEKEEPING	9.00	0	56,778	0	1.00
	0		0	56,778		
E - TELEPHONE AND POSTAGE						
1.00	DATA PROCESSING	5.02		130,596	0	1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.03	34,320		0	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00		569	0	3.00
	0		34,320	131,165		
G - RHC PHYSICIAN RECRUITMENT						
1.00	OTHER ADMIN AND GENERAL	5.04	0	2,447	0	1.00
	0		0	2,447		
I - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	690,471	12	1.00
	TOTALS		0	690,471		
J - DRUG COSTS						
1.00	PHARMACY	15.00	0	883,138	0	1.00
	TOTALS		0	883,138		
500.00	Grand Total: Decreases		206,839	2,022,474		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
5/19/2020 10:18 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
			1.00	2.00	3.00			4.00
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	51,361	0	0	0	0	1.00	
2.00	Land Improvements	864,526	1,522,132	0	1,522,132	0	2.00	
3.00	Buildings and Fixtures	11,230,711	14,498,955	0	14,498,955	177,980	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	599,547	283,160	0	283,160	0	5.00	
6.00	Movable Equipment	8,030,377	1,254,379	0	1,254,379	758,657	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	20,776,522	17,558,626	0	17,558,626	936,637	8.00	
9.00	Reconciling Items	-17,092,466	-4,202,437	17,572,035	13,369,598	0	9.00	
10.00	Total (line 8 minus line 9)	37,868,988	21,761,063	-17,572,035	4,189,028	936,637	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	51,361	0					1.00
2.00	Land Improvements	2,386,658	0					2.00
3.00	Buildings and Fixtures	25,551,686	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	882,707	0					5.00
6.00	Movable Equipment	8,526,099	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	37,398,511	0					8.00
9.00	Reconciling Items	-3,722,868	0					9.00
10.00	Total (line 8 minus line 9)	41,121,379	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,221,954	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	0	102,128	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	462,123	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,684,077	0	102,128	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,221,954				1.00
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	102,128				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	462,123				2.00
3.00	Total (sum of lines 1-2)	0	1,786,205				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	12,592,003	0	12,592,003	0.336698	19,958	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	16,280,409	0	16,280,409	0.435322	25,805	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	8,526,099	0	8,526,099	0.227980	13,514	2.00	
3.00	Total (sum of lines 1-2)	37,398,511	0	37,398,511	0.000000	59,277	3.00	
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
		6.00	7.00	8.00	9.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	19,958	1,221,954	0	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	0	25,805	0	0	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,514	462,036	0	2.00	
3.00	Total (sum of lines 1-2)	0	0	59,277	1,683,990	0	3.00	
Cost Center Description		SUMMARY OF CAPITAL						
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
		11.00	12.00	13.00	14.00	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	-670,513	0	0	551,441	1.00	
1.01	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	716,276	0	0	716,276	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,514	0	0	475,550	2.00	
3.00	Total (sum of lines 1-2)	0	59,277	0	0	1,743,267	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1341

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

Worksheet A-8

Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT NEW BDG EX (chapter 2)	B	-102,128	CAP REL COSTS-BLDG & FIXT NEW BDG EX	1.01	11	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0	0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,384	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,558,139			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-31,792	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			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-30,465	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines	B	-2,124	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT NEW BDG EX			0CAP REL COSTS-BLDG & FIXT NEW BDG EX	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN 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)	A	-38,671	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1341

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

Worksheet A-8

Date/Time Prepared:
5/19/2020 10:18 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 MISCELLANEOUS INCOME	B	-10,695	OTHER ADMIN AND GENERAL	5.04	0	33.00
34.00 SPORTS MEDICINE INCOME	B	-3,770	PHYSICAL THERAPY	66.00	0	34.00
35.00 ADVERTISING	A	-64,718	OTHER ADMIN AND GENERAL	5.04	0	35.00
36.00 PATIENT PHONE COSTS - CAPITAL	A	-87	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
36.01 PATIENT PHONE COSTS - BENEFITS	A	-348	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.01
36.02 PATIENT PHONE COSTS - SALARY	A	-2,253	NONPATIENT TELEPHONES	5.01	0	36.02
36.03 PATIENT PHONE COSTS - OTHER	A	-4,286	NONPATIENT TELEPHONES	5.01	0	36.03
38.00 SELF-INS CASH PMNTS TO HOSPITAL	A	-316,906	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00 PHYSICIAN RECRUITMENT	A	-2,257	OTHER ADMIN AND GENERAL	5.04	0	39.00
40.00 HOSPICE COSTS	A	38,671	HOSPICE	116.00	0	40.00
41.00 LOBBYING	A	-10,445	OTHER ADMIN AND GENERAL	5.04	0	41.00
44.00 MEDICAID TAX	A	-493,953	OTHER ADMIN AND GENERAL	5.04	0	44.00
45.00 GOODWILL AMORTIZATION	A	-18,066	OTHER ADMIN AND GENERAL	5.04	0	45.00
45.01 RHC NON-ALLOWABLE SALARIES	A	-5,351	RURAL HEALTH CLINIC	88.00	0	45.01
45.02 RHC NON-ALLOWABLE BENEFITS	A	-247	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03 PHYSICIAN BENEFITS	A	-45,842	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04 340B RETAIL PHARMACY COSTS	A	-62,398	PHARMACY	15.00	0	45.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,769,654				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1341

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

Worksheet A-8-2

Date/Time Prepared:
5/19/2020 10:18 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	13,000	1,116	11,884	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	55,830	55,830	0	0	0	2.00
3.00	91.00	EMERGENCY	1,734,543	924,556	809,987	0	0	3.00
4.00	50.00	OPERATING ROOM	269,088	269,088	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	307,549	307,549	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,380,010	1,558,139	821,871			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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	1,116		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	55,830		2.00
3.00	91.00	EMERGENCY	0	0	0	924,556		3.00
4.00	50.00	OPERATING ROOM	0	0	0	269,088		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	307,549		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,558,139		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1341		Period: From 01/01/2019 To 12/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/19/2020 10:18 am		
				Speech Pathology		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						9	1.00
2.00	Line 1 multiplied by 15 hours per week						135	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						9	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						0.00	7.00
8.00	Optional travel expense rate per mile						0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	42.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	43.54	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	21.77	21.77	0.00			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						1,829	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						1,829	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						1,829	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						43.55	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						5,879	22.00
23.00	Total salary equivalency (see instructions)						5,879	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						196	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						196	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						196	28.00
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						196	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1341

Period:
From 01/01/2019
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					Speech Pathology	Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	43.54	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						5,879	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						196	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						6,075	63.00
64.00	Total cost of outside supplier services (from your records)						3,437	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						196	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						196	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	BLDG & FIXT NEW BDG EX	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	551,441	551,441			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	716,276	0	716,276		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	475,550		475,550		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,824,653	0	0	1,824,653	4.00
5.01	00540	NONPATIENT TELEPHONES	158,377	346	0	5,081	5.01
5.02	00550	DATA PROCESSING	677,320	8,579	3,470	27,863	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	745,560	15,453	0	755	5.03
5.04	00590	OTHER ADMIN AND GENERAL	1,587,132	37,463	63,523	4,825	5.04
7.00	00700	OPERATION OF PLANT	725,539	147,630	257,464	3,716	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	56,778	0	0	0	8.00
9.00	00900	HOUSEKEEPING	312,847	8,715	2,067	1,581	9.00
10.00	01000	DIETARY	71,409	12,819	42,258	7,992	10.00
11.00	01100	CAFETERIA	117,765	0	25,892	0	11.00
13.00	01300	NURSING ADMINISTRATION	338,485	5,575	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,044	4,543	0	0	14.00
15.00	01500	PHARMACY	367,885	4,704	0	6,771	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	246,458	4,092	0	945	16.00
17.00	01700	SOCIAL SERVICE	67,344	507	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	259,111	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	959,895	47,724	0	5,979	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	687,161	11,120	219,734	124,202	50.00
53.00	05300	ANESTHESIOLOGY	22,183	0	0	12,119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,355,724	21,133	41,028	188,059	54.00
60.00	06000	LABORATORY	1,054,059	3,931	39,403	39,584	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	632,756	15,879	21,437	22,128	65.00
66.00	06600	PHYSICAL THERAPY	692,755	48,255	0	12,082	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,303	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	883,138	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,243,851	35,782	0	3,941	88.00
91.00	09100	EMERGENCY	1,846,115	20,459	0	8,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,076,334	20,274	0	2,589	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	678,911	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,545,159	474,983	716,276	474,090	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	692	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,718,254	64,956	0	973	192.00
194.00	07950	HOMEBOUND MEALS	87,237	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	142,283	9,574	0	0	194.01
194.02	07952	FOUNDATION	49,690	1,236	0	487	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	23,542,623	551,441	716,276	475,550	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.01	5.02	5.03	5A.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	163,804					5.01
5.02	00550	DATA PROCESSING	22,138	792,717				5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	11,384	55,214	885,231			5.03
5.04	00590	OTHER ADMIN AND GENERAL	6,957	35,495	0	1,872,166	1,872,166	5.04
7.00	00700	OPERATION OF PLANT	1,897	7,888	0	1,182,829	102,188	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	56,778	4,905	8.00
9.00	00900	HOUSEKEEPING	1,265	3,944	0	374,737	32,375	9.00
10.00	01000	DIETARY	2,530	15,775	0	158,472	13,691	10.00
11.00	01100	CAFETERIA	0	0	0	155,228	13,411	11.00
13.00	01300	NURSING ADMINISTRATION	1,897	11,832	0	410,217	35,440	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	632	3,944	0	94,961	8,204	14.00
15.00	01500	PHARMACY	2,530	15,775	0	438,336	37,869	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,795	19,719	0	300,180	25,933	16.00
17.00	01700	SOCIAL SERVICE	1,265	7,888	0	86,471	7,470	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	259,111	22,385	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,546	31,551	48,131	1,224,704	105,806	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,060	31,551	51,318	1,175,453	101,551	50.00
53.00	05300	ANESTHESIOLOGY	632	3,944	14,926	53,804	4,648	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,324	39,439	278,376	2,009,265	173,586	54.00
60.00	06000	LABORATORY	6,324	39,439	192,315	1,472,749	127,235	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,222	31,551	70,639	886,443	76,582	65.00
66.00	06600	PHYSICAL THERAPY	8,854	51,270	56,019	967,310	83,569	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,534	35,837	3,096	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	74,770	957,908	82,757	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	17,076	98,597	0	2,665,591	230,281	88.00
91.00	09100	EMERGENCY	10,119	31,551	95,203	2,148,233	185,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	9,487	43,383	0	1,281,222	110,689	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	67,046	0	800,765	69,180	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	142,934	646,796	885,231	21,068,770	1,658,443	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	632	0	0	1,324	114	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,341	126,202	0	2,129,166	183,945	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	93,987	8,120	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,265	15,775	0	185,980	16,067	194.01
194.02	07952	FOUNDATION	632	3,944	0	63,396	5,477	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	163,804	792,717	885,231	23,542,623	1,872,166	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	1,285,017					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	61,683				8.00
9.00	00900	HOUSEKEEPING	26,946	0	434,058			9.00
10.00	01000	DIETARY	68,376	0	26,876	267,415		10.00
11.00	01100	CAFETERIA	18,974	0	7,458	0	195,071	11.00
13.00	01300	NURSING ADMINISTRATION	16,269	0	6,395	0	5,392	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,257	0	5,211	0	1,766	14.00
15.00	01500	PHARMACY	13,726	0	5,395	0	4,056	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,940	0	4,693	0	4,883	16.00
17.00	01700	SOCIAL SERVICE	1,479	0	581	0	1,797	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,527	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	139,259	23,909	54,737	267,415	20,105	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	193,476	4,782	76,047	0	8,430	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	91,733	5,928	36,056	0	13,950	54.00
60.00	06000	LABORATORY	40,347	0	15,859	0	17,035	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	62,045	329	24,387	0	14,617	65.00
66.00	06600	PHYSICAL THERAPY	140,810	8,828	55,346	0	14,029	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	104,412	0	28,520	0	25,052	88.00
91.00	09100	EMERGENCY	59,700	17,907	23,466	0	19,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	59,159	0	23,253	0	3,404	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	1,591	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,061,908	61,683	394,280	267,415	157,405	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,020	0	794	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	189,544	0	26,585	0	31,542	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	27,938	0	10,981	0	4,533	194.01
194.02	07952	FOUNDATION	3,607	0	1,418	0	1,591	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,285,017	61,683	434,058	267,415	195,071	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
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	473,713					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	123,399				14.00
15.00	01500	PHARMACY	16,662	573	516,617			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	651	0	348,280		16.00
17.00	01700	SOCIAL SERVICE	7,382	117	0	0	105,297	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	6,273	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	82,589	7,025	0	17,674	84,238	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	34,630	23,927	0	18,844	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,139	0	5,481	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,304	10,917	0	102,240	0	54.00
60.00	06000	LABORATORY	69,979	22,309	0	70,618	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	60,047	6,507	0	25,939	0	65.00
66.00	06600	PHYSICAL THERAPY	57,631	1,703	0	20,570	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,857	0	1,298	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	516,617	27,456	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,036	0	0	0	88.00
91.00	09100	EMERGENCY	81,216	11,945	0	34,959	21,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	20,540	0	12,693	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	1,137	0	10,508	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	473,713	119,383	516,617	348,280	105,297	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	3,526	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	479	0	0	0	194.01
194.02	07952	FOUNDATION	0	11	0	0	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	473,713	123,399	516,617	348,280	105,297	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:
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Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMIN AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	289,296				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,027,461	-69,234	1,958,227	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,637,140	1,065	1,638,205	50.00
53.00	05300	ANESTHESIOLOGY	289,296	354,368	0	354,368	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,500,979	0	2,500,979	54.00
60.00	06000	LABORATORY	0	1,836,131	0	1,836,131	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	68,169	68,169	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,156,896	0	1,156,896	65.00
66.00	06600	PHYSICAL THERAPY	0	1,349,796	0	1,349,796	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,088	0	46,088	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,584,738	0	1,584,738	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,058,892	0	3,058,892	88.00
91.00	09100	EMERGENCY	0	2,603,848	0	2,603,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,510,960	0	1,510,960	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE		883,181	0	883,181	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	289,296	20,550,478	0	20,550,478	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,252	0	4,252	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,564,308	0	2,564,308	192.00
194.00	07950	HOMEBOUND MEALS	0	102,107	0	102,107	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	245,978	0	245,978	194.01
194.02	07952	FOUNDATION	0	75,500	0	75,500	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	289,296	23,542,623	0	23,542,623	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1341

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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	BLDG & FIXT NEW BDG EX	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	346	0	346	5.01
5.02	00550	DATA PROCESSING	0	8,579	3,470	27,863	5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,995	15,453	0	755	5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	37,463	63,523	4,825	5.04
7.00	00700	OPERATION OF PLANT	0	147,630	257,464	3,716	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,715	2,067	1,581	9.00
10.00	01000	DIETARY	0	12,819	42,258	7,992	10.00
11.00	01100	CAFETERIA	0	0	25,892	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,575	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,543	0	0	14.00
15.00	01500	PHARMACY	17,725	4,704	0	6,771	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,092	0	945	16.00
17.00	01700	SOCIAL SERVICE	0	507	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	47,724	0	5,979	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	94,645	11,120	219,734	124,202	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,119	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,133	41,028	188,059	54.00
60.00	06000	LABORATORY	0	3,931	39,403	39,584	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,123	15,879	21,437	22,128	65.00
66.00	06600	PHYSICAL THERAPY	0	48,255	0	12,082	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	13,200	35,782	0	3,941	88.00
91.00	09100	EMERGENCY	0	20,459	0	8,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	20,274	0	2,589	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	450	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,138	474,983	716,276	474,090	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	692	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,199	64,956	0	973	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	9,574	0	0	194.01
194.02	07952	FOUNDATION	0	1,236	0	487	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	136,337	551,441	716,276	475,550	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
			4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00540	NONPATIENT TELEPHONES	0	346				5.01
5.02	00550	DATA PROCESSING	0	48	39,960			5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	24	2,783	21,010		5.03
5.04	00590	OTHER ADMIN AND GENERAL	0	15	1,789	0	107,615	5.04
7.00	00700	OPERATION OF PLANT	0	4	398	0	5,874	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	282	8.00
9.00	00900	HOUSEKEEPING	0	3	199	0	1,861	9.00
10.00	01000	DIETARY	0	5	795	0	787	10.00
11.00	01100	CAFETERIA	0	0	0	0	771	11.00
13.00	01300	NURSING ADMINISTRATION	0	4	596	0	2,037	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1	199	0	472	14.00
15.00	01500	PHARMACY	0	5	795	0	2,177	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8	994	0	1,491	16.00
17.00	01700	SOCIAL SERVICE	0	3	398	0	429	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,287	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	31	1,590	1,143	6,082	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11	1,590	1,219	5,837	50.00
53.00	05300	ANESTHESIOLOGY	0	1	199	355	267	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13	1,988	6,595	9,978	54.00
60.00	06000	LABORATORY	0	13	1,988	4,568	7,314	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	17	1,590	1,678	4,402	65.00
66.00	06600	PHYSICAL THERAPY	0	19	2,584	1,331	4,804	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	84	178	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,776	4,757	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	36	4,970	0	13,234	88.00
91.00	09100	EMERGENCY	0	21	1,590	2,261	10,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	20	2,187	0	6,363	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	3,380	0	3,977	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	302	32,602	21,010	95,329	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1	0	0	7	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39	6,364	0	10,573	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	467	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	3	795	0	924	194.01
194.02	07952	FOUNDATION	0	1	199	0	315	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	346	39,960	21,010	107,615	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1341

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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT	415,086					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	282				8.00
9.00	00900	HOUSEKEEPING	8,704	0	23,130			9.00
10.00	01000	DIETARY	22,087	0	1,432	88,175		10.00
11.00	01100	CAFETERIA	6,129	0	397	0	33,189	11.00
13.00	01300	NURSING ADMINISTRATION	5,255	0	341	0	917	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,282	0	278	0	300	14.00
15.00	01500	PHARMACY	4,434	0	287	0	690	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,857	0	250	0	831	16.00
17.00	01700	SOCIAL SERVICE	478	0	31	0	306	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	260	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,983	109	2,917	88,175	3,421	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	62,496	22	4,053	0	1,434	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,632	27	1,921	0	2,373	54.00
60.00	06000	LABORATORY	13,033	0	845	0	2,898	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,042	2	1,300	0	2,487	65.00
66.00	06600	PHYSICAL THERAPY	45,484	40	2,949	0	2,387	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	33,727	0	1,520	0	4,262	88.00
91.00	09100	EMERGENCY	19,284	82	1,250	0	3,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	19,110	0	1,239	0	579	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	271	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	343,017	282	21,010	88,175	26,780	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	653	0	42	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	61,226	0	1,417	0	5,367	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	9,025	0	585	0	771	194.01
194.02	07952	FOUNDATION	1,165	0	76	0	271	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	415,086	282	23,130	88,175	33,189	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
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	14,725					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,075				14.00
15.00	01500	PHARMACY	518	47	38,153			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53	0	12,521		16.00
17.00	01700	SOCIAL SERVICE	229	10	0	0	2,391	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	195	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,568	574	0	636	1,913	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,076	1,954	0	678	0	50.00
53.00	05300	ANESTHESIOLOGY	0	93	0	197	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,781	891	0	3,670	0	54.00
60.00	06000	LABORATORY	2,175	1,821	0	2,540	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,867	531	0	933	0	65.00
66.00	06600	PHYSICAL THERAPY	1,791	139	0	740	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	478	0	47	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	38,153	988	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	411	0	0	0	88.00
91.00	09100	EMERGENCY	2,525	975	0	1,257	478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1,677	0	457	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	93	0	378	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,725	9,747	38,153	12,521	2,391	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	288	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	39	0	0	0	194.01
194.02	07952	FOUNDATION	0	1	0	0	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,725	10,075	38,153	12,521	2,391	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description			NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	00590	OTHER ADMIN AND GENERAL					5.04
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,742				19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		207,845	0	207,845	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		530,071	0	530,071	50.00
53.00	05300	ANESTHESIOLOGY		13,231	0	13,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		309,089	0	309,089	54.00
60.00	06000	LABORATORY		120,113	0	120,113	60.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		100,416	0	100,416	65.00
66.00	06600	PHYSICAL THERAPY		122,605	0	122,605	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		787	0	787	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		45,674	0	45,674	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC		111,083	0	111,083	88.00
91.00	09100	EMERGENCY		73,173	0	73,173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY		54,495	0	54,495	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE		8,549	0	8,549	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,697,131	0	1,697,131	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		1,395	0	1,395	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		153,402	0	153,402	192.00
194.00	07950	HOMEBOUND MEALS		467	0	467	194.00
194.01	07951	FITNESS WELLNESS PROGRAM		21,716	0	21,716	194.01
194.02	07952	FOUNDATION		3,751	0	3,751	194.02
194.03	07953	RETAIL 340B PHARMACY		0	0	0	194.03
200.00		Cross Foot Adjustments	1,742	1,742	0	1,742	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,742	1,879,604	0	1,879,604	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1341

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

Worksheet B-1

Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NEW BDG EX (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
		1.00	1.01	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	89,215				1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX	0	29,103			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		462,036			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,515,700		4.00
5.01	00540	NONPATIENT TELEPHONES	56	0	32,067	259	5.01
5.02	00550	DATA PROCESSING	1,388	141	27,071	336,684	35 5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,500	0	734	358,883	18 5.03
5.04	00590	OTHER ADMIN AND GENERAL	6,061	2,581	4,688	863,186	11 5.04
7.00	00700	OPERATION OF PLANT	23,884	10,461	3,610	244,208	3 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00	00900	HOUSEKEEPING	1,410	84	1,536	279,699	2 9.00
10.00	01000	DIETARY	2,074	1,717	7,765	35,907	4 10.00
11.00	01100	CAFETERIA	0	1,052	0	73,029	0 11.00
13.00	01300	NURSING ADMINISTRATION	902	0	0	330,883	3 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	735	0	0	36,595	1 14.00
15.00	01500	PHARMACY	761	0	6,579	256,685	4 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	662	0	918	158,858	6 16.00
17.00	01700	SOCIAL SERVICE	82	0	0	59,748	2 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,721	0	5,809	737,639	23 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,799	8,928	120,672	285,943	8 50.00
53.00	05300	ANESTHESIOLOGY	0	0	11,775	0	1 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,419	1,667	182,716	499,731	10 54.00
60.00	06000	LABORATORY	636	1,601	38,459	616,567	10 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	2,569	871	21,499	529,071	13 65.00
66.00	06600	PHYSICAL THERAPY	7,807	0	11,739	618,966	14 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,789	0	3,829	1,680,930	27 88.00
91.00	09100	EMERGENCY	3,310	0	8,704	857,229	16 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	3,280	0	2,515	815,120	15 101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	345,902	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	76,845	29,103	460,618	10,053,530	226 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	112	0	0	0	1 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,509	0	945	1,265,011	29 192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	42,598	0 194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,549	0	0	107,817	2 194.01
194.02	07952	FOUNDATION	200	0	473	46,744	1 194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0 194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	551,441	716,276	475,550	1,824,653	163,804 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.181035	24.611758	1.029249	0.158449	632.447876 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	346 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	1.335907 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: 14-1341

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			DATA PROCESSING (# OF TERMS) NALS)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVE NUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.02	5.03	5A.04	5.04	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	201					5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE	14	42,827,351				5.03
5.04	00590	OTHER ADMIN AND GENERAL	9	0	-1,872,166	21,670,457		5.04
7.00	00700	OPERATION OF PLANT	2	0	0	1,182,829	71,246	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	56,778	0	8.00
9.00	00900	HOUSEKEEPING	1	0	0	374,737	1,494	9.00
10.00	01000	DIETARY	4	0	0	158,472	3,791	10.00
11.00	01100	CAFETERIA	0	0	0	155,228	1,052	11.00
13.00	01300	NURSING ADMINISTRATION	3	0	0	410,217	902	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	0	0	94,961	735	14.00
15.00	01500	PHARMACY	4	0	0	438,336	761	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5	0	0	300,180	662	16.00
17.00	01700	SOCIAL SERVICE	2	0	0	86,471	82	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	259,111	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8	2,328,550	0	1,224,704	7,721	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8	2,482,751	0	1,175,453	10,727	50.00
53.00	05300	ANESTHESIOLOGY	1	722,092	0	53,804	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10	13,468,074	0	2,009,265	5,086	54.00
60.00	06000	LABORATORY	10	9,304,078	0	1,472,749	2,237	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8	3,417,482	0	886,443	3,440	65.00
66.00	06600	PHYSICAL THERAPY	13	2,710,174	0	967,310	7,807	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	170,952	0	35,837	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,617,328	0	957,908	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	25	0	0	2,665,591	5,789	88.00
91.00	09100	EMERGENCY	8	4,605,870	0	2,148,233	3,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	11	0	0	1,281,222	3,280	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	17	0	0	800,765	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	164	42,827,351	-1,872,166	19,196,604	58,876	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	1,324	112	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32	0	0	2,129,166	10,509	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	93,987	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	4	0	0	185,980	1,549	194.01
194.02	07952	FOUNDATION	1	0	0	63,396	200	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	792,717	885,231		1,872,166	1,285,017	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,943.865672	0.020670		0.086393	18.036339	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,960	21,010		107,615	415,086	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	198.805970	0.000491		0.004966	5.826096	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: 14-1341

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

Worksheet B-1

Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HR)	
			8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,106					8.00
9.00	00900	HOUSEKEEPING	0	61,227				9.00
10.00	01000	DIETARY	0	3,791	5,554			10.00
11.00	01100	CAFETERIA	0	1,052	0	255,091		11.00
13.00	01300	NURSING ADMINISTRATION	0	902	0	7,051	150,800	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	735	0	2,309	0	14.00
15.00	01500	PHARMACY	0	761	0	5,304	5,304	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	662	0	6,386	0	16.00
17.00	01700	SOCIAL SERVICE	0	82	0	2,350	2,350	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,997	1,997	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,476	7,721	5,554	26,291	26,291	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,296	10,727	0	11,024	11,024	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,044	5,086	0	18,242	18,242	54.00
60.00	06000	LABORATORY	0	2,237	0	22,277	22,277	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	502	3,440	0	19,115	19,115	65.00
66.00	06600	PHYSICAL THERAPY	13,468	7,807	0	18,346	18,346	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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	4,023	0	32,760	0	88.00
91.00	09100	EMERGENCY	27,320	3,310	0	25,854	25,854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	3,280	0	4,451	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	2,080	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,106	55,616	5,554	205,837	150,800	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	112	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,750	0	41,246	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	0	1,549	0	5,928	0	194.01
194.02	07952	FOUNDATION	0	200	0	2,080	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	61,683	434,058	267,415	195,071	473,713	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.655463	7.089323	48.148181	0.764711	3.141333	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	282	23,130	88,175	33,189	14,725	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002997	0.377775	15.875945	0.130107	0.097646	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: 14-1341

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

Worksheet B-1

Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NEW BDG EX						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	00590	OTHER ADMIN AND GENERAL						5.04
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	417,248					14.00
15.00	01500	PHARMACY	1,938	883,138				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,202	0	45,884,052			16.00
17.00	01700	SOCIAL SERVICE	397	0	0	100		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,753	0	2,328,550	80	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	80,900	0	2,482,751	0	0	50.00
53.00	05300	ANESTHESIOLOGY	3,850	0	722,092	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,915	0	13,468,074	0	0	54.00
60.00	06000	LABORATORY	75,433	0	9,304,078	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	22,002	0	3,417,482	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,759	0	2,710,174	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,805	0	170,952	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	883,138	3,617,328	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	17,029	0	0	0	0	88.00
91.00	09100	EMERGENCY	40,388	0	4,605,870	20	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	69,453	0	1,672,298	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	3,843	0	1,384,403	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	403,667	883,138	45,884,052	100	100	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	11,923	0	0	0	0	192.00
194.00	07950	HOMEBOUND MEALS	0	0	0	0	0	194.00
194.01	07951	FITNESS WELLNESS PROGRAM	1,620	0	0	0	0	194.01
194.02	07952	FOUNDATION	38	0	0	0	0	194.02
194.03	07953	RETAIL 340B PHARMACY	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	123,399	516,617	348,280	105,297	289,296	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.295745	0.584979	0.007590	1,052.970000	2,892.960000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,075	38,153	12,521	2,391	1,742	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.024146	0.043202	0.000273	23.910000	17.420000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 14-1341

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

Worksheet B-2

Date/Time Prepared:
5/19/2020 10:18 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		IV THERAPY & RECOVERY ROOM		1	30.00	-69,234 7.00
8.00		IV THERAPY		1	64.00	68,169 8.00
9.00		RECOVERY ROOM		1	50.00	1,065 9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/19/2020 10:18 am

			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	1,958,227		1,958,227	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,638,205		1,638,205	0	0	50.00
53.00	05300	ANESTHESIOLOGY	354,368		354,368	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,500,979		2,500,979	0	0	54.00
60.00	06000	LABORATORY	1,836,131		1,836,131	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	68,169		68,169	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,156,896	0	1,156,896	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,349,796	0	1,349,796	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	46,088		46,088	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,584,738		1,584,738	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,058,892		3,058,892	0	0	88.00
91.00	09100	EMERGENCY	2,603,848		2,603,848	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	80,058		80,058		0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	1,510,960		1,510,960		0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	883,181		883,181		0	116.00
200.00		Subtotal (see instructions)	20,630,536	0	20,630,536	0	0	200.00
201.00		Less Observation Beds	80,058		80,058		0	201.00
202.00		Total (see instructions)	20,550,478	0	20,550,478	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/19/2020 10:18 am

				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	1,691,502		1,691,502			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,233	2,433,884	2,441,117	0.671088	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	28,290	680,132	708,422	0.500222	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	676,262	12,644,181	13,320,443	0.187755	0.000000	54.00
60.00	06000	LABORATORY	804,673	8,438,667	9,243,340	0.198644	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	163,114	352,588	515,702	0.132187	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,591,710	1,815,780	3,407,490	0.339516	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	273,084	2,425,985	2,699,069	0.500097	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112,458	58,307	170,765	0.269891	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	704,070	2,906,133	3,610,203	0.438961	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,045,265	2,045,265			88.00
91.00	09100	EMERGENCY	225,525	4,359,938	4,585,463	0.567848	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	23,681	41,426	65,107	1.229637	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,672,298	1,672,298			101.00
	SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	1,384,403	1,384,403			116.00
200.00		Subtotal (see instructions)	6,301,602	41,258,987	47,560,589			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,301,602	41,258,987	47,560,589			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
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
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description			Title XVIII		Hospital		Cost	
			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	530,071	2,441,117	0.217143	7,233	1,571	50.00
53.00	05300	ANESTHESIOLOGY	13,231	708,422	0.018677	14,752	276	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,089	13,320,443	0.023204	483,207	11,212	54.00
60.00	06000	LABORATORY	120,113	9,243,340	0.012995	496,054	6,446	60.00
64.00	06400	INTRAVENOUS THERAPY	0	515,702	0.000000	105,995	0	64.00
65.00	06500	RESPIRATORY THERAPY	100,416	3,407,490	0.029469	950,463	28,009	65.00
66.00	06600	PHYSICAL THERAPY	122,605	2,699,069	0.045425	80,939	3,677	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	787	170,765	0.004609	70,092	323	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,674	3,610,203	0.012651	406,972	5,149	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	111,083	2,045,265	0.054312	0	0	88.00
91.00	09100	EMERGENCY	73,173	4,585,463	0.015958	15,083	241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,497	65,107	0.130508	1,205	157	92.00
200.00		Total (lines 50 through 199)	1,434,739	42,812,386		2,631,995	57,061	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1341

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

Worksheet D
Part IV
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description		Title XVIII		Hospital		Cost	
		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	50.00
53.00	05300	ANESTHESIOLOGY	289,296	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	289,296	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description			Title XVIII		Hospital	Cost	
			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	2,441,117	0.000000
53.00	05300	ANESTHESIOLOGY	0	289,296	0	708,422	0.408367
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,320,443	0.000000
60.00	06000	LABORATORY	0	0	0	9,243,340	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	0	0	515,702	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,407,490	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	2,699,069	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	170,765	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,610,203	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,045,265	0.000000
91.00	09100	EMERGENCY	0	0	0	4,585,463	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	65,107	0.000000
200.00		Total (lines 50 through 199)	0	289,296	0	42,812,386	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
5/19/2020 10:18 am

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	7,233	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	14,752	6,024	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	483,207	0	0	0
60.00	06000	LABORATORY	0.000000	496,054	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	105,995	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.000000	950,463	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	80,939	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	70,092	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	406,972	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	15,083	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,205	0	0	0
200.00		Total (lines 50 through 199)		2,631,995	6,024	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
5/19/2020 10:18 am

			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	0.671088	0	1,113,140	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.500222	0	305,881	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187755	0	5,415,851	0	0	54.00	
60.00	06000	LABORATORY	0.198644	0	3,471,498	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.132187	0	170,560	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.339516	0	1,025,611	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.500097	0	870,908	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.269891	0	29,960	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.438961	0	2,090,659	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
91.00	09100	EMERGENCY	0.567848	0	1,700,855	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.229637	0	39,559	0	0	92.00	
200.00		Subtotal (see instructions)		0	16,234,482	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	16,234,482	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
5/19/2020 10:18 am

				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	747,015	0		50.00
53.00	05300	ANESTHESIOLOGY	153,008	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,016,853	0		54.00
60.00	06000	LABORATORY	689,592	0		60.00
64.00	06400	INTRAVENOUS THERAPY	22,546	0		64.00
65.00	06500	RESPIRATORY THERAPY	348,211	0		65.00
66.00	06600	PHYSICAL THERAPY	435,538	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,086	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	917,718	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	965,827	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	48,643	0		92.00
200.00		Subtotal (see instructions)	5,353,037	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,353,037	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1341

Period:

Worksheet D

Component CCN: 14-Z341

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
5/19/2020 10:18 am

			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	0.671088	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.500222	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187755	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.198644	0	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.132187	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.339516	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.500097	0	0	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.269891	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.438961	0	0	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
91.00	09100	EMERGENCY	0.567848	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.229637	0	0	0	0	92.00	
200.00		Subtotal (see instructions)		0	0	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1341

Period:

Worksheet D

Component CCN: 14-Z341

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
5/19/2020 10:18 am

			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
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
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
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 5/19/2020 10:18 am
		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)		1,795	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,262	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)		1,189	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		522	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		11	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)		856	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)		482	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		157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,958,227	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)		1,729	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)		574,201	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,384,026	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)		1,384,026	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)		1,096.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		938,767	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)		938,767	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1341

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

Worksheet D-1

Date/Time Prepared:
5/19/2020 10:18 am

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					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)					786,290 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,725,057 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)					528,605 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)					528,605 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)					73 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,096.69 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					80,058 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1341

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

Worksheet D-1

Date/Time Prepared:
5/19/2020 10:18 am

		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	207,845	1,958,227	0.106139	80,058	8,497
91.00	Nursing School cost	0	1,958,227	0.000000	80,058	0
92.00	Allied health cost	0	1,958,227	0.000000	80,058	0
93.00	All other Medical Education	0	1,958,227	0.000000	80,058	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 5/19/2020 10:18 am	
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		891,280		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.671088	7,233	4,854	50.00
53.00	05300 ANESTHESIOLOGY	0.500222	14,752	7,379	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187755	483,207	90,725	54.00
60.00	06000 LABORATORY	0.198644	496,054	98,538	60.00
64.00	06400 INTRAVENOUS THERAPY	0.132187	105,995	14,011	64.00
65.00	06500 RESPIRATORY THERAPY	0.339516	950,463	322,697	65.00
66.00	06600 PHYSICAL THERAPY	0.500097	80,939	40,477	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.269891	70,092	18,917	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438961	406,972	178,645	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.567848	15,083	8,565	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.229637	1,205	1,482	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,631,995	786,290	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)		2,631,995		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1341 Component CCN: 14-Z341	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 5/19/2020 10:18 am	
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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.671088	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.500222	410	205	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187755	45,355	8,516	54.00
60.00	06000 LABORATORY	0.198644	82,729	16,434	60.00
64.00	06400 INTRAVENOUS THERAPY	0.132187	16,506	2,182	64.00
65.00	06500 RESPIRATORY THERAPY	0.339516	206,742	70,192	65.00
66.00	06600 PHYSICAL THERAPY	0.500097	151,140	75,585	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.269891	9,516	2,568	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.438961	134,393	58,993	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.567848	307	174	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.229637	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		647,098	234,849	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		647,098		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 5/19/2020 10:18 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,353,037	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)		5,353,037	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)		5,406,567	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)		48,325	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,495,444	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)		2,862,798	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)		2,862,798	30.00
31.00	Primary payer payments		516	31.00
32.00	Subtotal (line 30 minus line 31)		2,862,282	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)		410,428	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		266,778	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		289,978	36.00
37.00	Subtotal (see instructions)		3,129,060	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,129,060	40.00
40.01	Sequestration adjustment (see instructions)		62,581	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,747,246	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		319,233	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
5/19/2020 10:18 am

		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		1,349,792		2,264,771	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	06/20/2019	47,105	06/20/2019	106,481	3.01
3.02		12/30/2019	87,500	12/12/2019	29,276	3.02
3.03			0	12/19/2019	346,718	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)		134,605		482,475	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,484,397		2,747,246	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		8,914		319,233	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,493,311		3,066,479	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: 14-1341

Period:

Worksheet E-1

Component CCN: 14-Z341

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
5/19/2020 10:18 am

		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		653,721		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	06/20/2019	38,618		0	3.01
3.02		12/30/2019	45,470		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)		84,088		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)		737,809		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		11,194		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		749,003		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: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
5/19/2020 10:18 am

		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: 14-1341 Component CCN: 14-Z341	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2 Date/Time Prepared: 5/19/2020 10:18 am	
		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)		533,891	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)		237,197	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		482	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)		771,088	0	8.00
9.00	Primary payer payments (see instructions)		831	0	9.00
10.00	Subtotal (line 8 minus line 9)		770,257	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)		770,257	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		5,968	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)		764,289	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)		764,289	0	19.00
19.01	Sequestration adjustment (see instructions)		15,286	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		737,809	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)		11,194	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: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 5/19/2020 10:18 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,725,057	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)		1,725,057	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,742,308	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)		1,742,308	19.00
20.00	Deductibles (exclude professional component)		242,720	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,499,588	22.00
23.00	Coinsurance		7,843	23.00
24.00	Subtotal (line 22 minus line 23)		1,491,745	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		49,296	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		32,042	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		43,332	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,523,787	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)		1,523,787	30.00
30.01	Sequestration adjustment (see instructions)		30,476	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		1,484,397	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)		8,914	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1341

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

Worksheet G

Date/Time Prepared:
5/19/2020 10:18 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	5,824,727	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	4,692,098	0	0	0	4.00
5.00 Other receivable	61,038	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	475,465	0	0	0	7.00
8.00 Prepaid expenses	133,939	0	0	0	8.00
9.00 Other current assets	1,083,720	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)	12,270,987	0	0	0	11.00
FIXED ASSETS					
12.00 Land	51,361	0	0	0	12.00
13.00 Land improvements	2,386,658	0	0	0	13.00
14.00 Accumulated depreciation	-525,490	0	0	0	14.00
15.00 Buildings	25,551,686	0	0	0	15.00
16.00 Accumulated depreciation	-7,526,626	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	882,707	0	0	0	19.00
20.00 Accumulated depreciation	-544,455	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	8,526,099	0	0	0	23.00
24.00 Accumulated depreciation	-6,445,532	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	3,722,868	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	26,079,276	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	3,591,162	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	3,591,162	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	41,941,425	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	2,029,528	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,651,605	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	333,339	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	0	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	4,014,472	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	7,000,348	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)	7,000,348	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	11,014,820	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	30,926,605				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)	30,926,605	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	41,941,425	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1341

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

Worksheet G-1

Date/Time Prepared:
5/19/2020 10:18 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		29,398,215		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,011,229				2.00
3.00	Total (sum of line 1 and line 2)		30,409,444		0		3.00
4.00	RESTRICTED ASSET DONATIONS	415,526		0		0	4.00
5.00	GAIN ON INVESTMENT IN QUAD CTY HMS	101,635		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)		517,161		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,926,605		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)		30,926,605		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	RESTRICTED ASSET DONATIONS		0				4.00
5.00	GAIN ON INVESTMENT IN QUAD CTY HMS		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: 14-1341

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,326,397		1,326,397	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	357,570		357,570	5.00
6.00	Swing bed - NF	7,535		7,535	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)	1,691,502		1,691,502	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,691,502		1,691,502	17.00
18.00	Ancillary services	4,360,894	31,755,657	36,116,551	18.00
19.00	Outpatient services	249,206	4,401,364	4,650,570	19.00
20.00	RURAL HEALTH CLINIC	0	2,045,265	2,045,265	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,672,298	1,672,298	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,384,403	1,384,403	26.00
27.00	PROFEES	784,568	6,348,278	7,132,846	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,086,170	47,607,265	54,693,435	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,312,277		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	SPORTS MEDICINE REV NETTED WITH EXP	3,770			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)		3,770		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,308,507		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1341

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

Worksheet G-3

Date/Time Prepared:
5/19/2020 10:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	54,693,435	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,530,115	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,163,320	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,308,507	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-145,187	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	635,896	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	49,265	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	2,124	21.00
22.00	Rental of hospital space	60,860	22.00
23.00	Governmental appropriations	27,586	23.00
24.00	RETAIL PHARMACY	319,472	24.00
24.01	FITNESS CENTER REVENUE	95,391	24.01
24.02	MISC REVENUE	41,099	24.02
25.00	Total other income (sum of lines 6-24)	1,231,693	25.00
26.00	Total (line 5 plus line 25)	1,086,506	26.00
27.00	DISPOSAL OF FIXED ASSETS	75,277	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	75,277	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,011,229	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-1341

Period:

Worksheet H

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 amHome Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	113,255	0	85,920	0	50,540	249,715	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	461,680	0	0	0	0	461,680	6.00
7.00 Physical Therapy	137,747	0	0	80,224	0	217,971	7.00
8.00 Occupational Therapy	68,154	0	0	31,399	0	99,553	8.00
9.00 Speech Pathology	8,124	0	0	0	0	8,124	9.00
10.00 Medical Social Services	23,097	0	0	0	0	23,097	10.00
11.00 Home Health Aide	3,063	0	0	0	0	3,063	11.00
12.00 Supplies (see instructions)	0	0	0	0	13,131	13,131	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	815,120	0	85,920	111,623	63,671	1,076,334	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	0	249,715	0	249,715			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	461,680	0	461,680			6.00
7.00 Physical Therapy	0	217,971	0	217,971			7.00
8.00 Occupational Therapy	0	99,553	0	99,553			8.00
9.00 Speech Pathology	0	8,124	0	8,124			9.00
10.00 Medical Social Services	0	23,097	0	23,097			10.00
11.00 Home Health Aide	0	3,063	0	3,063			11.00
12.00 Supplies (see instructions)	0	13,131	0	13,131			12.00
13.00 Drugs	0	0	0	0			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	0	1,076,334	0	1,076,334			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-1341

Period:

Worksheet H-1

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
5/19/2020 10:18 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	249,715	0	0	0	0	249,715	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	461,680	0	0	0	0	461,680	6.00
7.00	Physical Therapy	217,971	0	0	0	0	217,971	7.00
8.00	Occupational Therapy	99,553	0	0	0	0	99,553	8.00
9.00	Speech Pathology	8,124	0	0	0	0	8,124	9.00
10.00	Medical Social Services	23,097	0	0	0	0	23,097	10.00
11.00	Home Health Aide	3,063	0	0	0	0	3,063	11.00
12.00	Supplies (see instructions)	13,131	0	0	0	0	13,131	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,076,334	0	0	0	0	1,076,334	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	249,715						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	139,471	601,151					6.00
7.00	Physical Therapy	65,847	283,818					7.00
8.00	Occupational Therapy	30,074	129,627					8.00
9.00	Speech Pathology	2,454	10,578					9.00
10.00	Medical Social Services	6,977	30,074					10.00
11.00	Home Health Aide	925	3,988					11.00
12.00	Supplies (see instructions)	3,967	17,098					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,076,334					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-1341

Period:

Worksheet H-1

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
5/19/2020 10:18 amHome Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Agency 1 Reconciliation	Administrative & General (ACCUM. COST)		
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)						
		1.00	2.00	3.00	4.00	5A.00	5.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00	
2.00	Capital Related - Movable Equipment		0			0		2.00	
3.00	Plant Operation & Maintenance	0	0	0		0		3.00	
4.00	Transportation (see instructions)	0	0	0	0			4.00	
5.00	Administrative and General	0	0	0	0	-249,715	826,619	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	461,680	6.00	
7.00	Physical Therapy	0	0	0	0	0	217,971	7.00	
8.00	Occupational Therapy	0	0	0	0	0	99,553	8.00	
9.00	Speech Pathology	0	0	0	0	0	8,124	9.00	
10.00	Medical Social Services	0	0	0	0	0	23,097	10.00	
11.00	Home Health Aide	0	0	0	0	0	3,063	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	13,131	12.00	
13.00	Drugs	0	0	0		0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	0	0	0	0	-249,715	826,619	24.00	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		249,715	25.00	
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.302092	26.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341

Period:

Worksheet H-2

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
5/19/2020 10:18 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			BLDG & FIXT	BLDG & FIXT NEW BDG EX	MVBLE EQUIP			
		0	1.00	1.01	2.00	4.00	5.01	
1.00	Administrative and General	0	14,909	0	2,589	17,945	1,897	1.00
2.00	Skilled Nursing Care	601,151	0	0	0	73,153	4,428	2.00
3.00	Physical Therapy	283,818	0	0	0	21,826	1,265	3.00
4.00	Occupational Therapy	129,627	0	0	0	10,799	632	4.00
5.00	Speech Pathology	10,578	0	0	0	1,287	0	5.00
6.00	Medical Social Services	30,074	0	0	0	3,660	0	6.00
7.00	Home Health Aide	3,988	0	0	0	485	0	7.00
8.00	Supplies (see instructions)	17,098	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	5,365	0	0	0	1,265	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,076,334	20,274	0	2,589	129,155	9,487	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		DATA PROCESSING	CASHIERING/ACC OUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.02	5.03	5A.03	5.04	7.00	8.00	
1.00	Administrative and General	11,832	0	49,172	4,248	43,504	0	1.00
2.00	Skilled Nursing Care	19,719	0	698,451	60,343	0	0	2.00
3.00	Physical Therapy	3,944	0	310,853	26,856	0	0	3.00
4.00	Occupational Therapy	0	0	141,058	12,186	0	0	4.00
5.00	Speech Pathology	0	0	11,865	1,025	0	0	5.00
6.00	Medical Social Services	0	0	33,734	2,914	0	0	6.00
7.00	Home Health Aide	0	0	4,473	386	0	0	7.00
8.00	Supplies (see instructions)	0	0	17,098	1,477	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	7,888	0	14,518	1,254	15,655	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	43,383	0	1,281,222	110,689	59,159	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341

Period:

Worksheet H-2

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
5/19/2020 10:18 amHome Health
Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	17,099	0	3,404	0	3,743	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	6,154	0	0	0	16,797	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	23,253	0	3,404	0	20,540	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	19.00	24.00	25.00	26.00	
1.00	Administrative and General	12,693	0	0	133,863	0	133,863	1.00
2.00	Skilled Nursing Care	0	0	0	758,794	0	758,794	2.00
3.00	Physical Therapy	0	0	0	337,709	0	337,709	3.00
4.00	Occupational Therapy	0	0	0	153,244	0	153,244	4.00
5.00	Speech Pathology	0	0	0	12,890	0	12,890	5.00
6.00	Medical Social Services	0	0	0	36,648	0	36,648	6.00
7.00	Home Health Aide	0	0	0	4,859	0	4,859	7.00
8.00	Supplies (see instructions)	0	0	0	18,575	0	18,575	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	54,378	0	54,378	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	12,693	0	0	1,510,960	0	1,510,960	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-1341

Period:

Worksheet H-2

HHA CCN: 14-7299

From 01/01/2019

Part I

To 12/31/2019

Date/Time Prepared:

5/19/2020 10:18 am

Home Health
Agency I

PPS

Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	73,760	832,554		2.00
3.00	Physical Therapy	32,828	370,537		3.00
4.00	Occupational Therapy	14,896	168,140		4.00
5.00	Speech Pathology	1,253	14,143		5.00
6.00	Medical Social Services	3,562	40,210		6.00
7.00	Home Health Aide	472	5,331		7.00
8.00	Supplies (see instructions)	1,806	20,381		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	5,286	59,664		19.00
19.50	Telemedicine	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	133,863	1,510,960		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.097207			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1341

Period:

Worksheet H-2

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
5/19/2020 10:18 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONE S)	DATA PROCESSING (# OF TERMINALS)	
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NEW BDG EX (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	1.01	2.00	4.00	5.01	5.02	
1.00	Administrative and General	2,412	0	2,515	113,255	3	3	1.00
2.00	Skilled Nursing Care	0	0	0	461,680	7	5	2.00
3.00	Physical Therapy	0	0	0	137,747	2	1	3.00
4.00	Occupational Therapy	0	0	0	68,154	1	0	4.00
5.00	Speech Pathology	0	0	0	8,124	0	0	5.00
6.00	Medical Social Services	0	0	0	23,097	0	0	6.00
7.00	Home Health Aide	0	0	0	3,063	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	868	0	0	0	2	2	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	3,280	0	2,515	815,120	15	11	20.00
21.00	Total cost to be allocated	20,274	0	2,589	129,155	9,487	43,383	21.00
22.00	Unit cost multiplier	6.181098	0.000000	1.029423	0.158449	632.466667	3,943.909091	22.00
Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.03	5A.04	5.04	7.00	8.00	9.00	
1.00	Administrative and General	0	0	49,172	2,412	0	2,412	1.00
2.00	Skilled Nursing Care	0	0	698,451	0	0	0	2.00
3.00	Physical Therapy	0	0	310,853	0	0	0	3.00
4.00	Occupational Therapy	0	0	141,058	0	0	0	4.00
5.00	Speech Pathology	0	0	11,865	0	0	0	5.00
6.00	Medical Social Services	0	0	33,734	0	0	0	6.00
7.00	Home Health Aide	0	0	4,473	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	17,098	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	14,518	868	0	868	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	1,281,222	3,280	0	3,280	20.00
21.00	Total cost to be allocated	0	0	110,689	59,159	0	23,253	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.086393	18.036280	0.000000	7.089329	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-1341
HHA CCN: 14-7299Period:
From 01/01/2019
To 12/31/2019Worksheet H-2
Part II
Date/Time Prepared:
5/19/2020 10:18 am

				Home Health Agency I		PPS	
Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)
		10.00	11.00	13.00	14.00	15.00	16.00
1.00	Administrative and General	0	4,451	0	12,655	0	1,672,298
2.00	Skilled Nursing Care	0	0	0	0	0	0
3.00	Physical Therapy	0	0	0	0	0	0
4.00	Occupational Therapy	0	0	0	0	0	0
5.00	Speech Pathology	0	0	0	0	0	0
6.00	Medical Social Services	0	0	0	0	0	0
7.00	Home Health Aide	0	0	0	0	0	0
8.00	Supplies (see instructions)	0	0	0	0	0	0
9.00	Drugs	0	0	0	0	0	0
10.00	DME	0	0	0	0	0	0
11.00	Home Dialysis Aide Services	0	0	0	0	0	0
12.00	Respiratory Therapy	0	0	0	0	0	0
13.00	Private Duty Nursing	0	0	0	0	0	0
14.00	Clinic	0	0	0	0	0	0
15.00	Health Promotion Activities	0	0	0	0	0	0
16.00	Day Care Program	0	0	0	0	0	0
17.00	Home Delivered Meals Program	0	0	0	0	0	0
18.00	Homemaker Service	0	0	0	0	0	0
19.00	All Others (specify)	0	0	0	56,798	0	0
19.50	Telemedicine	0	0	0	0	0	0
20.00	Total (sum of lines 1-19)	0	4,451	0	69,453	0	1,672,298
21.00	Total cost to be allocated	0	3,404	0	20,540	0	12,693
22.00	Unit cost multiplier	0.000000	0.764772	0.000000	0.295740	0.000000	0.007590
Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		17.00	19.00				
1.00	Administrative and General	0	0				
2.00	Skilled Nursing Care	0	0				
3.00	Physical Therapy	0	0				
4.00	Occupational Therapy	0	0				
5.00	Speech Pathology	0	0				
6.00	Medical Social Services	0	0				
7.00	Home Health Aide	0	0				
8.00	Supplies (see instructions)	0	0				
9.00	Drugs	0	0				
10.00	DME	0	0				
11.00	Home Dialysis Aide Services	0	0				
12.00	Respiratory Therapy	0	0				
13.00	Private Duty Nursing	0	0				
14.00	Clinic	0	0				
15.00	Health Promotion Activities	0	0				
16.00	Day Care Program	0	0				
17.00	Home Delivered Meals Program	0	0				
18.00	Homemaker Service	0	0				
19.00	All Others (specify)	0	0				
19.50	Telemedicine	0	0				
20.00	Total (sum of lines 1-19)	0	0				
21.00	Total cost to be allocated	0	0				
22.00	Unit cost multiplier	0.000000	0.000000				

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet H-3

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
5/19/2020 10:18 am

				Title XVIII		Home Health Agency I	PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	832,554		832,554	3,767	221.01	1.00
2.00	Physical Therapy	3.00	370,537	0	370,537	3,324	111.47	2.00
3.00	Occupational Therapy	4.00	168,140	0	168,140	1,301	129.24	3.00
4.00	Speech Pathology	5.00	14,143	0	14,143	135	104.76	4.00
5.00	Medical Social Services	6.00	40,210		40,210	30	1,340.33	5.00
6.00	Home Health Aide	7.00	5,331		5,331	34	156.79	6.00
7.00	Total (sum of lines 1-6)		1,430,915	0	1,430,915	8,591		7.00
				Program Visits				
				Part B				
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		99914	0	2,208			8.00
8.01	Skilled Nursing Care		41180	0	3			8.01
9.00	Physical Therapy		99914	0	2,395			9.00
9.01	Physical Therapy		41180	0	38			9.01
10.00	Occupational Therapy		99914	0	905			10.00
10.01	Occupational Therapy		41180	0	1			10.01
11.00	Speech Pathology		99914	0	87			11.00
11.01	Speech Pathology		41180	0	0			11.01
12.00	Medical Social Services		99914	0	14			12.00
12.01	Medical Social Services		41180	0	0			12.01
13.00	Home Health Aide		99914	0	26			13.00
13.01	Home Health Aide		41180	0	0			13.01
14.00	Total (sum of lines 8-13)			0	5,677			14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	20,381	0	20,381	13,041	1.562840	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
				Program Visits		Cost of Services		
				Part B		Part B		
				Not Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		
				Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	2,211		0	488,653		1.00
2.00	Physical Therapy	0	2,433		0	271,207		2.00
3.00	Occupational Therapy	0	906		0	117,091		3.00
4.00	Speech Pathology	0	87		0	9,114		4.00
5.00	Medical Social Services	0	14		0	18,765		5.00
6.00	Home Health Aide	0	26		0	4,077		6.00
7.00	Total (sum of lines 1-6)	0	5,677		0	908,907		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet H-3

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
5/19/2020 10:18 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description						Agency 1		
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	10,812	0	0	16,897	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	488,653						1.00
2.00	Physical Therapy	271,207						2.00
3.00	Occupational Therapy	117,091						3.00
4.00	Speech Pathology	9,114						4.00
5.00	Medical Social Services	18,765						5.00
6.00	Home Health Aide	4,077						6.00
7.00	Total (sum of lines 1-6)	908,907						7.00
Cost Center Description								
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet H-3

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
5/19/2020 10:18 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.500097	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.269891	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.438961	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1341

Period:

Worksheet H-4

HHA CCN: 14-7299

From 01/01/2019
To 12/31/2019Part I-II
Date/Time Prepared:
5/19/2020 10:18 am

Title XVIII

Home Health
Agency I

PPS

		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			1.00	2.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	1,079,472	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	8,471	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	16,359	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	8,346	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,409	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	1,115,057	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	1,115,057	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	1,115,057	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	1,115,057	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	1,115,057	31.00
31.01	Sequestration adjustment (see instructions)		0	22,301	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	1,092,756	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIESProvider CCN: 14-1341
HHA CCN: 14-7299Period:
From 01/01/2019
To 12/31/2019Worksheet H-5
Date/Time Prepared:
5/19/2020 10:18 am

				Home Health Agency I	PPS
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		0		1,092,756
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
3.01			0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50			0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,092,756
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01			0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50			0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		0		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		0		1,092,756
				Contractor Number	NPR Date (Mo/Day/Yr)
		0		1.00	2.00
8.00	Name of Contractor				

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0 2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0 3.00
4.00	ADMINISTRATIVE & GENERAL*	0	0	0	0	0 4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0 5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0 6.00
7.00	HOUSEKEEPING*	0	0	0	0	0 7.00
8.00	DIETARY*	0	0	0	0	0 8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0 9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0 10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0 11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0 12.00
13.00	VOLUNTEER SERVICE COORDINATION*	8,285	0	8,285	0	8,285 13.00
14.00	PHARMACY*	44,158	122,784	166,942	0	166,942 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0 15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					0 17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		0	0	0	0 25.00
26.00	PHYSICIAN SERVICES**	2,875	0	2,875	0	2,875 26.00
27.00	NURSE PRACTITIONER**	716	0	716	0	716 27.00
28.00	REGISTERED NURSE**	195,443	0	195,443	0	195,443 28.00
29.00	LPN/LVN**	0	0	0	0	0 29.00
30.00	PHYSICAL THERAPY**	58	0	58	0	58 30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0 31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0 32.00
33.00	MEDICAL SOCIAL SERVICES**	25,986	0	25,986	0	25,986 33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0 34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0 35.00
36.00	COUNSELING - OTHER**	15,351	0	15,351	0	15,351 36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	53,030	0	53,030	0	53,030 37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0 38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0 39.00
40.00	IMAGING SERVICES**	0	0	0	0	0 40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0 41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	98,265	98,265	0	98,265 42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	72,929	72,929	0	72,929 42.50
43.00	OUTPATIENT SERVICES**	0	360	360	0	360 43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0 46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0 60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0 61.00
62.00	FUNDRAISING*	0	0	0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0 65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0 66.00
67.00	ADVERTISING*	0	0	0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0 68.00
69.00	THRIFT STORE*	0	0	0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0 70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0 71.00
100.00	TOTAL	345,902	294,338	640,240	0	640,240 100.00

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

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

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I	
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	0		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	8,285		13.00
14.00	PHARMACY*	0	166,942		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	2,875		26.00
27.00	NURSE PRACTITIONER**	0	716		27.00
28.00	REGISTERED NURSE**	38,671	234,114		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	58		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	25,986		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	15,351		36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	53,030		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	98,265		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	72,929		42.50
43.00	OUTPATIENT SERVICES**	0	360		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	38,671	678,911		100.00

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

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

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

Provider CCN: 14-1341

Period:

Worksheet 0-2

Hospice CCN: 14-1575

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

Date/Time Prepared:
5/19/2020 10:18 am

				Hospice I		07/10/2025 10:10 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	2,865	0	2,865	0	2,865	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	195,443	0	195,443	0	195,443	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	58	0	58	0	58	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	25,891	0	25,891	0	25,891	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	15,295	0	15,295	0	15,295	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	52,836	0	52,836	0	52,836	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	98,265	98,265	0	98,265	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	72,663	72,663	0	72,663	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	292,388	170,928	463,316	0	463,316	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	2,865	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	38,671	234,114	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	58	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	25,891	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	15,295	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	52,836	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	98,265	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	72,663	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	38,671	501,987	100.00

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

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

Provider CCN: 14-1341

Period:

Worksheet 0-3

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	10	0	10	0	10	26.00
27.00	NURSE PRACTITIONER	716	0	716	0	716	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	95	0	95	0	95	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	56	0	56	0	56	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	194	0	194	0	194	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	266	266	0	266	42.50
43.00	OUTPATIENT SERVICES	0	360	360	0	360	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	1, 071	626	1, 697	0	1, 697	100.00

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

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	10	26.00
27.00	NURSE PRACTITIONER	0	716	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	95	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	56	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	194	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	266	42.50
43.00	OUTPATIENT SERVICES	0	360	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	1,697	100.00

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

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

Provider CCN: 14-1341

Period:

Worksheet 0-4

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

				Hospice I		07/10/2020 10:10 am	
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0		0	0	0	26.00
27.00	NURSE PRACTITIONER	0		0	0	0	27.00
28.00	REGISTERED NURSE	0		0	0	0	28.00
29.00	LPN/LVN	0		0	0	0	29.00
30.00	PHYSICAL THERAPY	0		0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0		0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0		0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0		0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0		0	0	0	34.00
35.00	DIETARY COUNSELING	0		0	0	0	35.00
36.00	COUNSELING - OTHER	0		0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0		0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0		0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0		0	0	0	39.00
40.00	IMAGING SERVICES	0		0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0		0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0		0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0		0	0	0	42.50
43.00	OUTPATIENT SERVICES	0		0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0		0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0		0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0		0	0	0	46.00
100.00	TOTAL *	0		0	0	0	100.00

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

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

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

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

Provider CCN: 14-1341

Period:

Worksheet 0-5

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	54,808	54,808	3.00
4.00	ADMINISTRATIVE & GENERAL	0	137,817	137,817	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	1,137	1,137	10.00
11.00	MEDICAL RECORDS	0	10,508	10,508	11.00
12.00	STAFF TRANSPORTATION	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	8,285	0	8,285	13.00
14.00	PHARMACY	166,942	0	166,942	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	501,987	0	501,987	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,697	0	1,697	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	678,911	204,270	883,181	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
5/19/2020 10:18 am

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0		1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0		0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	54,808		0	0	54,808		3.00
4.00	ADMINISTRATIVE & GENERAL	137,817		0	0	27,520	165,337	4.00
5.00	PLANT OPERATION & MAINTENANCE	0		0	0	4,833	4,833	5.00
6.00	LAUNDRY & LINEN SERVICE	0		0	0	0	0	6.00
7.00	HOUSEKEEPING	0		0	0	0	0	7.00
8.00	DIETARY	0		0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0		0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	1,137		0	0	0	1,137	10.00
11.00	MEDICAL RECORDS	10,508		0	0	0	10,508	11.00
12.00	STAFF TRANSPORTATION	0		0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	8,285		0	0	907	9,192	13.00
14.00	PHARMACY	166,942		0	0	0	166,942	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0		0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0	0	0	0	17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	501,987				21,468	523,455	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,697		0	0	80	1,777	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0		0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0		0	0	0	0	61.00
62.00	FUNDRAISING	0		0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0		0	0	0	0	66.00
67.00	ADVERTISING	0		0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	0	0	0	68.00
69.00	THRIFT STORE	0		0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0		0	0	0	0	99.00
100.00	TOTAL	883,181		0	0	54,808	883,181	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2019
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Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	165,337						4.00
5.00	PLANT OPERATION & MAINTENANCE	1,113	5,946					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	0	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	262	0			0		10.00
11.00	MEDICAL RECORDS	2,420	0			0		11.00
12.00	STAFF TRANSPORTATION	0	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	2,117	0			0		13.00
14.00	PHARMACY	38,451	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	0	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0						50.00
51.00	HOSPICE ROUTINE HOME CARE	120,565						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	409	5,946		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	165,337	5,946		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2019
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Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	1,399				10.00
11.00	MEDICAL RECORDS	0		12,928			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	11,309	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	1,394	12,881	0	11,268	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	5	47	0	41	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	1,399	12,928	0	11,309	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Part I
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Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	205,393					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	205,393	0	0		874,956	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	8,225	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	205,393	0	0	0	883,181	100.00

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

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	500,806			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	251,477	-165,337	717,844	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	44,158	0	4,833	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	1,137	10.00
11.00	MEDICAL RECORDS	0	0	0	0	10,508	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	8,285	0	9,192	13.00
14.00	PHARMACY	0	0	0	0	166,942	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			196,159	0	523,455	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	727	0	1,777	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	54,808		165,337	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.109440		0.230324	101.00

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

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Part II
Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	5,993					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5,993	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	5,946	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	0.992158	0.000000	0.000000	0.000000	0.000000	101.00

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

Provider CCN: 14-1341

Period:

Worksheet 0-6

Hospice CCN: 14-1575

From 01/01/2019
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Date/Time Prepared:
5/19/2020 10:18 am

Cost Center Descriptions		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)		MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00		11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL							4.00
5.00	PLANT OPERATION & MAINTENANCE							5.00
6.00	LAUNDRY & LINEN SERVICE							6.00
7.00	HOUSEKEEPING							7.00
8.00	DIETARY							8.00
9.00	NURSING ADMINISTRATION							9.00
10.00	ROUTINE MEDICAL SUPPLIES	8,217						10.00
11.00	MEDICAL RECORDS		8,217					11.00
12.00	STAFF TRANSPORTATION				0			12.00
13.00	VOLUNTEER SERVICE COORDINATION				0	8,217		13.00
14.00	PHARMACY				0	0	208,600	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	0	15.00
16.00	OTHER GENERAL SERVICE				0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES							17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	8,187	8,187	0	0	8,187	208,600	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	30	30	0	0	30	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM				0	0	0	60.00
61.00	VOLUNTEER PROGRAM				0	0	0	61.00
62.00	FUNDRAISING				0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM				0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES				0	0	0	65.00
66.00	RESIDENTIAL CARE				0	0	0	66.00
67.00	ADVERTISING				0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING				0	0	0	68.00
69.00	THRIFT STORE				0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	0	71.00
99.00	NEGATIVE COST CENTER							99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	1,399	12,928	0	0	11,309	205,393	100.00
101.00	UNIT COST MULTIPLIER	0.170257	1.573324	0.000000	0.000000	1.376293	0.984626	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASISProvider CCN: 14-1341
Hospice CCN: 14-1575Period:
From 01/01/2019
To 12/31/2019Worksheet 0-6
Part II
Date/Time Prepared:
5/19/2020 10:18 am

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

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

Provider CCN: 14-1341

Period:

Worksheet 0-7

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

Hospice I

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.500097	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.438961	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.198644	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.269891	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (from Provider Records)	Shared Service Costs by LOC				
		HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-1341

Period:

Worksheet 0-8

Hospice CCN: 14-1575

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			874,956	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			8,187	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			106.87	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	7,181	431		9.00
10.00	Program cost (line 8 times line 9)	767,433	46,061		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			8,225	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			30	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			274.17	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	28	2		14.00
15.00	Program cost (line 13 times line 14)	7,677	548		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			883,181	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			8,217	22.00
23.00	Average cost per diem (line 21 divided by line 22)			107.48	23.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341

Period:

Worksheet M-1

Component CCN: 14-8508

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	808,523	0	808,523	0	808,523	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	276,911	0	276,911	0	276,911	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	327,175	0	327,175	0	327,175	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)	1,412,609	0	1,412,609	0	1,412,609	10.00
11.00	Physician Services Under Agreement	28,580	0	28,580	0	28,580	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	127,991	127,991	0	127,991	13.00
14.00	Subtotal (sum of lines 11 through 13)	28,580	127,991	156,571	0	156,571	14.00
15.00	Medical Supplies	0	75,637	75,637	0	75,637	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	28,287	28,287	0	28,287	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	103,924	103,924	0	103,924	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,441,189	231,915	1,673,104	0	1,673,104	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	2,072	2,072	0	2,072	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,072	2,072	0	2,072	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	54,290	54,290	0	54,290	29.00
30.00	Administrative Costs	245,092	272,197	517,289	2,447	519,736	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	245,092	326,487	571,579	2,447	574,026	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,686,281	560,474	2,246,755	2,447	2,249,202	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1341

Period:

Worksheet M-1

Component CCN: 14-8508

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	-5,351	803,172		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	276,911		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	327,175		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)	-5,351	1,407,258		10.00
11.00	Physician Services Under Agreement	0	28,580		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	127,991		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	156,571		14.00
15.00	Medical Supplies	0	75,637		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	28,287		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	103,924		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-5,351	1,667,753		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	2,072		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,072		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	54,290		29.00
30.00	Administrative Costs	0	519,736		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	574,026		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,351	2,243,851		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1341

Period:

Worksheet M-2

Component CCN: 14-8508

From 01/01/2019
To 12/31/2019Date/Time Prepared:
5/19/2020 10:18 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.18	8,705	4,200	9,156		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.99	4,352	2,100	4,179		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.17	13,057		13,335	13,335	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	0.14	294			294	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)	4.31	13,351			13,629	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)					1,667,753	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,072	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,669,825	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.998759	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					574,026	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					815,041	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,389,067	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,389,067	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,387,343	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,055,096	20.00

Health Financial Systems		PANA COMMUNITY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1341	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3	
		Component CCN: 14-8508		Date/Time Prepared: 5/19/2020 10:18 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,055,096	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			53,728	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,001,368	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,629	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			13,629	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			220.22	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)		220.22	220.22	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,052	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	672,111	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	39	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	8,589	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	8,589	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	680,700	16.00
16.01	Total program charges (see instructions)(from contractor's records)			658,896	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			43,051	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			44,476	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.)			456,648	16.04
16.05	Total program cost (see instructions)		0	501,124	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			65,414	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			110,092	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			501,124	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			15,184	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			516,308	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)			516,308	26.00
26.01	Sequestration adjustment (see instructions)			10,326	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			490,465	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)			15,517	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: 14-1341 Component CCN: 14-8508	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 5/19/2020 10:18 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,407,258	1,407,258	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000387	0.000744	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		545	1,047	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		23,531	4,207	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		24,076	5,254	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,667,753	1,667,753	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,387,343	1,387,343	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.014436	0.003150	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		20,028	4,370	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		44,104	9,624	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		140	269	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		315.03	35.78	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		34	125	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		10,711	4,473	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)			53,728	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)			15,184	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1341 Component CCN: 14-8508	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 5/19/2020 10:18 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		478,220	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		06/20/2019	12,245	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)		12,245	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		490,465	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		15,517	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		505,982	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00