

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: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/28/2020 1:49 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/28/2020	Time: 1:49 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (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 UNION COUNTY HOSPITAL DISTRICT (14-1342) 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) MIKE HARBOR

Officer or Administrator of Provider(s)

CFO

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	160,621	361,841	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	100,075	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-17,392		0	10.00
200.00	Total	0	260,696	344,449	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: 14-1342		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:49 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 517 NORTH MAIN STREET			PO Box:				1.00		
2.00	City: ANNA			State: IL		Zip Code: 62906		County: UNION		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		UNION COUNTY HOSPITAL DISTRICT	141342	99914	1	07/01/1966	N	O	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		UNION COUNTY HOSP DIST SWING BEDS	14Z342	99914		08/05/1992	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		UNION COUNTY HOSP DIST RHC	143975	99914		05/22/1991	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		
21.00	Type of Control (see instructions)						4			
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
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Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S	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 OPSS 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	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1342		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:49 pm	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.			N			60.00
				Y/N	IME	Direct GME	
				1.00	2.00	3.00	
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)					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	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	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						62.00
62.01	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	62.01
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
63.00	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.						64.00
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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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	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				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
	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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:49 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	39,625	4,691	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1342		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/28/2020 1:49 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: QUORUM HEALTH CORPORATION		Contractor's Name: WISCONSIN PHYSICIAN SERVICES		Contractor's Number: 52280		141.00		
142.00	Street: 1573 MALLORY LANE		PO Box: SUITE 100				142.00		
143.00	City: BRENTWOOD		State: TN		Zip Code: 37027		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		11/27/2019	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.							N		148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N		149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			Y	Y	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
							1.00		
Multicampus									
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N		165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
							1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y		167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							1.00		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 8/28/2020 1:49 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/20/2020	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		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.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUCIE	GREENE		41.00
42.00	Enter the employer/company name of the cost report preparer.	QUORUM HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3747	LUCIE_GREENE@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1342

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	38,328.00	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)		25	9,125	38,328.00	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)		25	9,125	38,328.00	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	46.00	22	8,030			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		47				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: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,006	28	1,597			1.00
2.00	HMO and other (see instructions)	189	109				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	525	0	718			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,531	28	2,315			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)	1,531	28	2,315	0.00	121.81	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			5,335	0.00	15.69	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,014	0	8,482	0.00	6.45	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	143.95	27.00
28.00	Observation Bed Days		0	241			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: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	275	10	470	1.00
2.00 HMO and other (see instructions)			51	40		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	275	10	470	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	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 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

Health Financial Systems		UNION COUNTY HOSPITAL DISTRICT		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1342 Component CCN: 14-3975		Period: From 01/01/2019 To 12/31/2019 Worksheet S-8 Date/Time Prepared: 8/28/2020 1:49 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street	517 NORTH MAIN STREET			
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ANNA		IL 62906	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)				
5.00	Migrant Health Center (Section 329(d), PHS Act)				
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				
7.00	Appalachian Regional Commission				
8.00	Look-Alikes				
9.00	OTHER (SPECIFY)				
		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	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N			12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County	UNION			
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1342

Period:

Worksheet S-8

Component CCN: 14-3975

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/28/2020 1:49 pm

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	08:00	17:00	09:00	16:50		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 8/28/2020 1:49 pm	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.240601		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,029,980		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		2,532,837		5.00
6.00	Medicaid charges		20,354,650		6.00
7.00	Medicaid cost (line 1 times line 6)		4,897,349		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)		334,532		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)		334,532		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)	1,004,631	0	1,004,631	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	241,715	0	241,715	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	241,715	0	241,715	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)		2,574,458		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		725,160		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,115,630		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,458,828		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		741,465		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		983,180		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,317,712		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1342

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

Worksheet A

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		170,063	170,063	109,906	279,969	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,240,605	1,240,605	160,670	1,401,275	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	116,061	22,709	138,770	1,364,362	1,503,132	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	256,153	711,727	967,880	53,521	1,021,401	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	980,475	4,540,694	5,521,169	-1,667,694	3,853,475	5.02
7.00	00700	OPERATION OF PLANT	277,525	660,719	938,244	6,828	945,072	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,826	4,540	34,366	0	34,366	8.00
9.00	00900	HOUSEKEEPING	242,123	87,013	329,136	26,403	355,539	9.00
10.00	01000	DIETARY	13,589	569,723	583,312	0	583,312	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	952,591	92,804	1,045,395	-401,887	643,508	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	87,024	146,507	233,531	-115,258	118,273	14.00
15.00	01500	PHARMACY	317,598	484,667	802,265	-407,639	394,626	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	102,732	132,777	235,509	-18,717	216,792	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	668,344	950,801	1,619,145	470,565	2,089,710	30.00
46.00	04600	OTHER LONG TERM CARE	694,350	128,365	822,715	-35,856	786,859	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	268,427	152,411	420,838	73,410	494,248	50.00
51.00	05100	RECOVERY ROOM	65,459	12,161	77,620	-77,620	0	51.00
53.00	05300	ANESTHESIOLOGY	0	273,670	273,670	0	273,670	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	352,704	195,028	547,732	389,261	936,993	54.00
54.01	05401	ULTRASOUND	79,461	21,716	101,177	-101,177	0	54.01
56.00	05600	RADIOISOTOPE	0	78,669	78,669	-78,669	0	56.00
57.00	05700	CT SCAN	0	36,748	36,748	-36,748	0	57.00
58.00	05800	MRI	68,621	104,046	172,667	-172,667	0	58.00
60.00	06000	LABORATORY	421,371	534,835	956,206	-73,854	882,352	60.00
65.00	06500	RESPIRATORY THERAPY	66,646	38,536	105,182	-31,615	73,567	65.00
66.00	06600	PHYSICAL THERAPY	376,793	40,341	417,134	-1,138	415,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,823	13,182	181,005	0	181,005	67.00
68.00	06800	SPEECH PATHOLOGY	84,651	7,845	92,496	0	92,496	68.00
69.00	06900	ELECTROCARDIOLOGY	74,773	46,599	121,372	0	121,372	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	129,156	129,156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,388	21,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	367,678	367,678	73.00
76.00	03610	SLEEP LAB	0	97,298	97,298	0	97,298	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	270,644	270,644	0	270,644	76.01
76.03	03950	WOUND CARE	24,483	29,465	53,948	0	53,948	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	604,463	465,242	1,069,705	-58,568	1,011,137	88.00
91.00	09100	EMERGENCY	913,858	1,281,694	2,195,552	-963	2,194,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,307,924	13,643,844	21,951,768	-106,922	21,844,846	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	12,854	12,854	0	12,854	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	0	0	106,922	106,922	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	-335	-335	0	-335	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	8,307,924	13,656,363	21,964,287	0	21,964,287	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1342

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

Worksheet A

Date/Time Prepared:
8/28/2020 1:49 pm

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	505,450	785,419	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-744,143	657,132	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,503,132	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	-151,443	869,958	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-1,065,406	2,788,069	5.02
7.00	00700	OPERATION OF PLANT	-1,203	943,869	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,366	8.00
9.00	00900	HOUSEKEEPING	0	355,539	9.00
10.00	01000	DIETARY	0	583,312	10.00
11.00	01100	CAFETERIA	-38,627	-38,627	11.00
13.00	01300	NURSING ADMINISTRATION	0	643,508	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	118,273	14.00
15.00	01500	PHARMACY	0	394,626	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-185	216,607	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-806,099	1,283,611	30.00
46.00	04600	OTHER LONG TERM CARE	-43,976	742,883	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	494,248	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	273,670	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	936,993	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	882,352	60.00
65.00	06500	RESPIRATORY THERAPY	0	73,567	65.00
66.00	06600	PHYSICAL THERAPY	0	415,996	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	181,005	67.00
68.00	06800	SPEECH PATHOLOGY	0	92,496	68.00
69.00	06900	ELECTROCARDIOLOGY	0	121,372	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	129,156	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	367,678	73.00
76.00	03610	SLEEP LAB	0	97,298	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	270,644	76.01
76.03	03950	WOUND CARE	0	53,948	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-315,049	696,088	88.00
91.00	09100	EMERGENCY	-140,341	2,054,248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,801,022	19,043,824	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,854	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	106,922	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	-335	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	194.04
194.05	07955	VACANT SPACE	0	0	194.05
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,801,022	19,163,265	200.00

RECLASSIFICATIONS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet A-6
Date/Time Prepared:
8/28/2020 1:49 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,364,362		1.00
	0		0	1,364,362		
	B - OXYGEN					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	31,615		1.00
	0		0	31,615		
	C - RENTAL AND LEASE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	158,443		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
	0		0	158,443		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	28,266		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,227		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	81,640		3.00
	0		0	112,133		
	E - MARKETING DEPT					
1.00	OTHER NONREIMBURSABLE - MARKETING	194.01	68,189	38,733		1.00
	0		68,189	38,733		
	F - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	97,541		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	21,388		2.00
	0		0	118,929		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	367,678		1.00
	0		0	367,678		
	J - OTHER RADIOLOGY COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	148,082	241,179		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		148,082	241,179		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	65,459	12,161		1.00
	0		65,459	12,161		
	M - RHC SALARY TO ADMIN					
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	57,430	0		1.00
	0		57,430	0		
	N - INFECTION CONTROL					
1.00	NURSING ADMINISTRATION	13.00	66,275	9,862		1.00
	0		66,275	9,862		
	O - RECLASS COSTS TO HSKP AND MAINT					
1.00	OPERATION OF PLANT	7.00	8,948	0		1.00
2.00	HOUSEKEEPING	9.00	26,403	0		2.00
	0		35,351	0		
	P - HOUSE SUPVR TO ADULT AND PED					
1.00	ADULTS & PEDIATRICS	30.00	478,024	0		1.00
	0		478,024	0		
500.00	Grand Total: Increases		918,810	2,455,095		500.00

RECLASSIFICATIONS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet A-6
Date/Time Prepared:
8/28/2020 1:49 pm

Decreases						wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	1,364,362	0		1.00
	0		0	1,364,362			
	B - OXYGEN						
1.00	RESPIRATORY THERAPY	65.00	0	31,615	0		1.00
	0		0	31,615			
	C - RENTAL AND LEASE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	8,140	10		1.00
2.00	OPERATION OF PLANT	7.00	0	2,120	0		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	3,909	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	18,717	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	7,459	0		5.00
6.00	OTHER LONG TERM CARE	46.00	0	505	0		6.00
7.00	LABORATORY	60.00	0	73,854	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	1,138	0		8.00
9.00	EMERGENCY	91.00	0	963	0		9.00
10.00	OPERATING ROOM	50.00	0	471	0		10.00
11.00	RURAL HEALTH CLINIC	88.00	0	1,138	0		11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	68	0		12.00
13.00	PHARMACY	15.00	0	39,961	0		13.00
	0		0	158,443			
	D - OTHER CAPITAL COSTS						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	112,133	12		1.00
2.00		0.00	0	0	12		2.00
3.00		0.00	0	0	13		3.00
	0		0	112,133			
	E - MARKETING DEPT						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	68,189	38,733	0		1.00
	0		68,189	38,733			
	F - MED SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	115,190	0		1.00
2.00	OPERATING ROOM	50.00	0	3,739	0		2.00
	0		0	118,929			
	G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	367,678	0		1.00
	0		0	367,678			
	J - OTHER RADIOLOGY COSTS						
1.00	ULTRASOUND	54.01	79,461	21,716	0		1.00
2.00	RADIOISOTOPE	56.00	0	78,669	0		2.00
3.00	CT SCAN	57.00	0	36,748	0		3.00
4.00	MRI	58.00	68,621	104,046	0		4.00
	0		148,082	241,179			
	K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	65,459	12,161	0		1.00
	0		65,459	12,161			
	M - RHC SALARY TO ADMIN						
1.00	RURAL HEALTH CLINIC	88.00	57,430	0	0		1.00
	0		57,430	0			
	N - INFECTION CONTROL						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	66,275	9,862	0		1.00
	0		66,275	9,862			
	O - RECLASS COSTS TO HSKP AND MAINT						
1.00	OTHER LONG TERM CARE	46.00	35,351	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		35,351	0			
	P - HOUSE SUPVR TO ADULT AND PED						
1.00	NURSING ADMINISTRATION	13.00	478,024	0	0		1.00
	0		478,024	0			
500.00	Grand Total: Decreases		918,810	2,455,095			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	124,306	59,020	0	59,020	0	2.00	
3.00	Buildings and Fixtures	6,846,397	0	0	0	0	3.00	
4.00	Building Improvements	12,289,422	917,683	0	917,683	119	4.00	
5.00	Fixed Equipment	2,355,268	33,935	0	33,935	14,286	5.00	
6.00	Movable Equipment	8,210,861	938,142	0	938,142	765,576	6.00	
7.00	HIT designated Assets	3,248,805	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	33,075,059	1,948,780	0	1,948,780	779,981	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	33,075,059	1,948,780	0	1,948,780	779,981	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	183,326	0				2.00	
3.00	Buildings and Fixtures	6,846,397	0				3.00	
4.00	Building Improvements	13,206,986	0				4.00	
5.00	Fixed Equipment	2,374,917	0				5.00	
6.00	Movable Equipment	8,383,427	0				6.00	
7.00	HIT designated Assets	3,248,805	0				7.00	
8.00	Subtotal (sum of lines 1-7)	34,243,858	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	34,243,858	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	170,063	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,240,605	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,410,668	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	170,063				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,240,605				2.00
3.00	Total (sum of lines 1-2)	0	1,410,668				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	22,611,626	0	22,611,626	0.660312	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,632,232	0	11,632,232	0.339688	0	2.00
3.00	Total (sum of lines 1-2)	34,243,858	0	34,243,858	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	675,513	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	496,462	158,443	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,171,975	158,443	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	28,266	81,640	0	785,419	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,227	0	0	657,132	2.00
3.00	Total (sum of lines 1-2)	0	30,493	81,640	0	1,442,551	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1342

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

Worksheet A-8

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,400	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)	A	-468	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-946,440			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	357,969			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-38,627	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	-185	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-151,443	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	470,078	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-764,097	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1342

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

Worksheet A-8

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00			
33.00	FITNESS REVENUE	B	-15,756	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.00
33.02	IL PROVIDER TAX	B	-1,065,470	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.02
34.00	LOBBY EXPENSE	A	-8,250	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	34.00
34.01	CHARITABLE CONTRIBUTIONS	A	-106,945	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	34.01
35.00	PATIENT PHONES BENEFIT COST	A	-285	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	PATIENT PHONES DEPRECIATION COST	A	-1,057	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
37.00	CABLE TV EXPENSE	A	-1,203	OPERATION OF PLANT	7.00	0	37.00
38.00	MARKETING EXPENSE - EXCLUDING MARKET	A	-67,500	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38.00
39.00	IL PROVIDER TAX FOR NH	A	-43,567	OTHER LONG TERM CARE	46.00	9	39.00
40.00	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-9,878	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	40.00
41.00	MISCELLANEOUS INCOME	B	-3,592	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
41.01	PATIENT PHONE WAGES	A	-3,703	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.01
41.02	MIS AMORTIZATION ADJUSTMENT	A	-81,655	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.02
42.00	ADMIN SERVICES ALLOCATED TO RHC	A	-315,049	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	FLOWERS SENT FOR DECEASED NH RESIDEN	A	-409	OTHER LONG TERM CARE	46.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,801,022				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-1342

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

Worksheet A-8-1

Date/Time Prepared:
8/28/2020 1:49 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL RELATED COSTS(INT &	35,372	0
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED (MOVEABLE)	21,479	0
3.00		5.02	OTHER ADMINISTRATIVE AND GEN	ALLOCATED COSTS	665,198	472,790
4.00		5.02	OTHER ADMINISTRATIVE AND GEN	MALPRACTICE COSTS	44,316	-64,394
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.				766,365	408,396

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	QHC	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-1342

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

Worksheet A-8-1

Date/Time Prepared:
8/28/2020 1:49 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	35,372	9		1.00
2.00	21,479	9		2.00
3.00	192,408	0		3.00
4.00	108,710	0		4.00
5.00	357,969			5.00

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

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

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

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

6.00	HOSPITAL MANAGE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1342

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

Worksheet A-8-2

Date/Time Prepared:
8/28/2020 1:49 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	806,099	806,099	0	0	0	1.00
2.00	91.00	EMERGENCY	1,079,548	140,341	939,207	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,885,647	946,440	939,207			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	806,099		1.00
2.00	91.00	EMERGENCY	0	0	0	140,341		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	946,440		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACC OUNTS RECEIVABLE	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	785,419	785,419			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	657,132		657,132		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,503,132	6,136	5,181	1,514,449	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	869,958	14,954	12,626	57,973	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	2,788,069	149,271	126,035	156,404	5.02
7.00	00700	OPERATION OF PLANT	943,869	112,778	95,224	52,961	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,366	13,247	11,185	5,514	8.00
9.00	00900	HOUSEKEEPING	355,539	10,124	8,548	49,643	9.00
10.00	01000	DIETARY	583,312	25,015	21,121	2,512	10.00
11.00	01100	CAFETERIA	-38,627	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	643,508	21,774	18,385	99,987	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,273	15,449	13,045	16,088	14.00
15.00	01500	PHARMACY	394,626	9,683	8,176	58,715	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	216,607	8,999	7,598	18,992	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,283,611	56,086	47,356	211,935	30.00
46.00	04600	OTHER LONG TERM CARE	742,883	46,733	39,459	121,830	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	494,248	30,843	26,043	61,726	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	273,670	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	936,993	49,659	41,930	92,581	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	882,352	13,742	11,603	77,900	60.00
65.00	06500	RESPIRATORY THERAPY	73,567	2,069	1,747	12,321	65.00
66.00	06600	PHYSICAL THERAPY	415,996	34,840	29,417	69,658	66.00
67.00	06700	OCCUPATIONAL THERAPY	181,005	7,866	6,642	31,026	67.00
68.00	06800	SPEECH PATHOLOGY	92,496	1,093	923	15,650	68.00
69.00	06900	ELECTROCARDIOLOGY	121,372	5,970	5,041	13,823	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	129,156	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,388	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	367,678	0	0	0	73.00
76.00	03610	SLEEP LAB	97,298	2,800	2,365	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	270,644	6,065	5,121	0	76.01
76.03	03950	WOUND CARE	53,948	4,830	4,078	4,526	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	696,088	26,163	22,091	101,131	88.00
91.00	09100	EMERGENCY	2,054,248	35,736	30,174	168,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,043,824	711,925	601,114	1,501,843	955,511
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,697	3,122	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,854	45,231	38,191	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	106,922	3,076	2,597	12,606	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	-335	3,579	3,022	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	10,761	9,086	0	194.04
194.05	07955	VACANT SPACE	0	7,150	0	0	194.05
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)	19,163,265	785,419	657,132	1,514,449	955,511

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet B
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Cost Center Description			Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	3,219,779	3,219,779				5.02
7.00	00700	OPERATION OF PLANT	1,204,832	242,727	1,447,559			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,312	12,956	38,405	115,673		8.00
9.00	00900	HOUSEKEEPING	423,854	85,390	29,351	3,161	541,756	9.00
10.00	01000	DIETARY	631,960	127,315	72,523	715	28,726	10.00
11.00	01100	CAFETERIA	-38,627	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	783,654	157,876	63,104	0	25,004	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	162,855	32,809	44,791	0	17,741	14.00
15.00	01500	PHARMACY	471,200	94,928	28,074	0	11,120	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	252,196	50,808	26,090	0	10,334	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,646,493	331,704	162,605	22,637	64,408	30.00
46.00	04600	OTHER LONG TERM CARE	959,814	193,365	135,490	55,361	53,667	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	664,107	133,792	89,422	5,803	35,420	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	283,820	57,179	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,473,239	296,800	143,974	4,584	57,027	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,132,777	228,210	39,842	0	15,781	60.00
65.00	06500	RESPIRATORY THERAPY	94,265	18,991	5,998	0	2,376	65.00
66.00	06600	PHYSICAL THERAPY	588,443	118,548	101,007	8,263	40,009	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,729	47,289	26,136	0	9,033	67.00
68.00	06800	SPEECH PATHOLOGY	114,200	23,007	4,014	0	1,256	68.00
69.00	06900	ELECTROCARDIOLOGY	163,961	33,032	17,310	0	6,856	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,092	28,022	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,314	4,495	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	448,862	90,428	0	0	0	73.00
76.00	03610	SLEEP LAB	106,454	21,446	8,119	0	3,216	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	282,980	57,009	17,583	0	6,965	76.01
76.03	03950	WOUND CARE	69,080	13,917	21,939	0	5,546	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	859,869	173,230	75,830	909	30,045	88.00
91.00	09100	EMERGENCY	2,441,192	491,813	103,607	14,240	41,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		18,901,706	3,167,086	1,255,214	115,673	465,568	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,819	1,374	10,719	0	4,246	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	96,276	19,396	131,134	0	51,942	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	125,201	25,223	8,917	0	3,532	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	6,266	1,262	10,377	0	4,110	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	19,847	3,998	31,198	0	12,358	194.04
194.05	07955	VACANT SPACE	7,150	1,440	0	0	0	194.05
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)	19,163,265	3,219,779	1,447,559	115,673	541,756	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	861,239					10.00
11.00	01100	CAFETERIA	237,843	199,216				11.00
13.00	01300	NURSING ADMINISTRATION	0	8,867	1,038,505			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,303	0	262,499		14.00
15.00	01500	PHARMACY	0	5,885	0	6,858	618,065	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,584	0	1,511	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	192,331	36,748	469,530	22,188	0	30.00
46.00	04600	OTHER LONG TERM CARE	431,065	31,405	0	5,716	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11,029	136,753	34,195	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,426	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,193	0	12,734	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	15,032	0	82,836	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,422	27,297	926	0	65.00
66.00	06600	PHYSICAL THERAPY	0	12,930	0	2,640	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,043	0	246	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,801	0	816	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,102	30,626	735	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	36,439	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,557	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	618,065	73.00
76.00	03610	SLEEP LAB	0	0	0	1,597	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	1,301	0	1,285	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	12,910	0	8,355	0	88.00
91.00	09100	EMERGENCY	0	24,659	374,299	31,439	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	861,239	197,214	1,038,505	262,499	618,065	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	2,002	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	861,239	199,216	1,038,505	262,499	618,065	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1342

Period:
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To 12/31/2019Worksheet B
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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
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	345,523				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,180	2,965,824	0	2,965,824	30.00
46.00	04600	OTHER LONG TERM CARE	3,222	1,869,105	0	1,869,105	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,533	1,129,054	0	1,129,054	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	3,671	348,096	0	348,096	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127,294	2,132,845	0	2,132,845	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	53,227	1,567,705	0	1,567,705	60.00
65.00	06500	RESPIRATORY THERAPY	1,649	153,924	0	153,924	65.00
66.00	06600	PHYSICAL THERAPY	13,935	885,775	0	885,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,962	324,438	0	324,438	67.00
68.00	06800	SPEECH PATHOLOGY	1,460	146,554	0	146,554	68.00
69.00	06900	ELECTROCARDIOLOGY	6,421	261,043	0	261,043	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,593	207,146	0	207,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	335	35,701	0	35,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,360	1,186,715	0	1,186,715	73.00
76.00	03610	SLEEP LAB	1,443	142,275	0	142,275	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	416	364,953	0	364,953	76.01
76.03	03950	WOUND CARE	614	113,682	0	113,682	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,206	1,166,354	0	1,166,354	88.00
91.00	09100	EMERGENCY	55,002	3,577,289	0	3,577,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	345,523	18,578,478	0	18,578,478	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,158	0	23,158	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	298,748	0	298,748	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	164,875	0	164,875	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	22,015	0	22,015	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	67,401	0	67,401	194.04
194.05	07955	VACANT SPACE	0	8,590	0	8,590	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	345,523	19,163,265	0	19,163,265	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,136	5,181	11,317	11,317	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	14,954	12,626	27,580	433	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	149,271	126,035	275,306	1,168	5.02
7.00	00700	OPERATION OF PLANT	0	112,778	95,224	208,002	396	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,247	11,185	24,432	41	8.00
9.00	00900	HOUSEKEEPING	0	10,124	8,548	18,672	371	9.00
10.00	01000	DIETARY	0	25,015	21,121	46,136	19	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,774	18,385	40,159	747	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,449	13,045	28,494	120	14.00
15.00	01500	PHARMACY	0	9,683	8,176	17,859	439	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,999	7,598	16,597	142	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	56,086	47,356	103,442	1,587	30.00
46.00	04600	OTHER LONG TERM CARE	0	46,733	39,459	86,192	910	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	30,843	26,043	56,886	461	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,659	41,930	91,589	692	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	13,742	11,603	25,345	582	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,069	1,747	3,816	92	65.00
66.00	06600	PHYSICAL THERAPY	0	34,840	29,417	64,257	520	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,866	6,642	14,508	232	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,093	923	2,016	117	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,970	5,041	11,011	103	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	2,800	2,365	5,165	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	6,065	5,121	11,186	0	76.01
76.03	03950	WOUND CARE	0	4,830	4,078	8,908	34	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	26,163	22,091	48,254	755	88.00
91.00	09100	EMERGENCY	0	35,736	30,174	65,910	1,262	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0	711,925	601,114	1,313,039	11,223	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,697	3,122	6,819	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	45,231	38,191	83,422	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	3,076	2,597	5,673	94	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	3,579	3,022	6,601	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	10,761	9,086	19,847	0	194.04
194.05	07955	VACANT SPACE	0	7,150	0	7,150	0	194.05
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	785,419	657,132	1,442,551	11,317	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	28,013					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	276,474				5.02
7.00	00700	OPERATION OF PLANT	0	20,842	229,240			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,113	6,082	31,668		8.00
9.00	00900	HOUSEKEEPING	0	7,332	4,648	865	31,888	9.00
10.00	01000	DIETARY	0	10,932	11,485	196	1,691	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,556	9,993	0	1,472	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,817	7,093	0	1,044	14.00
15.00	01500	PHARMACY	0	8,151	4,446	0	655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,363	4,132	0	608	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,394	28,483	25,750	6,197	3,790	30.00
46.00	04600	OTHER LONG TERM CARE	261	16,604	21,457	15,156	3,159	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,503	11,488	14,161	1,589	2,085	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	298	4,910	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,311	25,486	22,800	1,255	3,357	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,318	19,596	6,309	0	929	60.00
65.00	06500	RESPIRATORY THERAPY	134	1,631	950	0	140	65.00
66.00	06600	PHYSICAL THERAPY	1,130	10,179	15,996	2,262	2,355	66.00
67.00	06700	OCCUPATIONAL THERAPY	240	4,061	4,139	0	532	67.00
68.00	06800	SPEECH PATHOLOGY	118	1,976	636	0	74	68.00
69.00	06900	ELECTROCARDIOLOGY	521	2,836	2,741	0	404	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	291	2,406	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27	386	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,382	7,765	0	0	0	73.00
76.00	03610	SLEEP LAB	117	1,842	1,286	0	189	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	34	4,895	2,785	0	410	76.01
76.03	03950	WOUND CARE	50	1,195	3,474	0	326	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	422	14,875	12,009	249	1,768	88.00
91.00	09100	EMERGENCY	4,462	42,230	16,408	3,899	2,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,013	271,950	198,780	31,668	27,404	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	118	1,697	0	250	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,665	20,767	0	3,057	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	2,166	1,412	0	208	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	108	1,643	0	242	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	343	4,941	0	727	194.04
194.05	07955	VACANT SPACE	0	124	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,013	276,474	229,240	31,668	31,888	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	70,459					10.00
11.00	01100	CAFETERIA	19,458	16,298				11.00
13.00	01300	NURSING ADMINISTRATION	0	725	66,652			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	352	0	39,920		14.00
15.00	01500	PHARMACY	0	481	0	1,043	33,074	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	375	0	230	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,735	3,008	30,134	3,374	0	30.00
46.00	04600	OTHER LONG TERM CARE	35,266	2,569	0	869	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	902	8,777	5,200	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	521	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,407	0	1,937	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,230	0	12,599	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	198	1,752	141	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,058	0	401	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	331	0	37	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	147	0	124	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	172	1,966	112	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,541	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,301	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	33,074	73.00
76.00	03610	SLEEP LAB	0	0	0	243	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	106	0	195	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,056	0	1,271	0	88.00
91.00	09100	EMERGENCY	0	2,017	24,023	4,781	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,459	16,134	66,652	39,920	33,074	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	164	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	3,160	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	70,459	19,458	66,652	39,920	33,074	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
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	26,447				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,317	224,211	0	224,211	30.00
46.00	04600	OTHER LONG TERM CARE	247	182,690	0	182,690	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,421	104,473	0	104,473	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	281	6,010	0	6,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,720	168,554	0	168,554	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	4,080	74,988	0	74,988	60.00
65.00	06500	RESPIRATORY THERAPY	126	8,980	0	8,980	65.00
66.00	06600	PHYSICAL THERAPY	1,068	99,226	0	99,226	66.00
67.00	06700	OCCUPATIONAL THERAPY	227	24,307	0	24,307	67.00
68.00	06800	SPEECH PATHOLOGY	112	5,320	0	5,320	68.00
69.00	06900	ELECTROCARDIOLOGY	492	20,358	0	20,358	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	275	8,513	0	8,513	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26	1,740	0	1,740	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,250	45,471	0	45,471	73.00
76.00	03610	SLEEP LAB	111	8,953	0	8,953	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	32	19,342	0	19,342	76.01
76.03	03950	WOUND CARE	47	14,335	0	14,335	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	399	81,058	0	81,058	88.00
91.00	09100	EMERGENCY	4,216	171,624	0	171,624	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,447	1,270,153	0	1,270,153	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,884	0	8,884	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	108,911	0	108,911	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	0	9,717	0	9,717	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	8,594	0	8,594	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	25,858	0	25,858	194.04
194.05	07955	VACANT SPACE	0	7,274	0	7,274	194.05
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	3,160	0	3,160	201.00
202.00		TOTAL (sum lines 118 through 201)	26,447	1,442,551	0	1,442,551	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1342

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

Worksheet B-1

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS CHAR GES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00				
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,847					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		98,938				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	780	780	8,191,863			4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,901	1,901	313,583	77,216,844		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	18,976	18,976	846,011	0	-3,219,779	5.02
7.00	00700	OPERATION OF PLANT	14,337	14,337	286,473	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,684	1,684	29,826	0	0	8.00
9.00	00900	HOUSEKEEPING	1,287	1,287	268,526	0	0	9.00
10.00	01000	DIETARY	3,180	3,180	13,589	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	38,627	11.00
13.00	01300	NURSING ADMINISTRATION	2,768	2,768	540,842	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,964	1,964	87,024	0	0	14.00
15.00	01500	PHARMACY	1,231	1,231	317,598	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,144	1,144	102,732	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,130	7,130	1,146,368	3,839,092	0	30.00
46.00	04600	OTHER LONG TERM CARE	5,941	5,941	658,999	720,012	0	46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,921	3,921	333,886	4,141,506	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	820,241	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,313	6,313	500,786	28,450,402	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,747	1,747	421,371	11,894,313	0	60.00
65.00	06500	RESPIRATORY THERAPY	263	263	66,646	368,558	0	65.00
66.00	06600	PHYSICAL THERAPY	4,429	4,429	376,793	3,113,954	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,000	1,000	167,823	661,898	0	67.00
68.00	06800	SPEECH PATHOLOGY	139	139	84,651	326,346	0	68.00
69.00	06900	ELECTROCARDIOLOGY	759	759	74,773	1,434,901	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	802,952	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	74,807	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,560,892	0	73.00
76.00	03610	SLEEP LAB	356	356	0	322,518	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	771	771	0	92,960	0	76.01
76.03	03950	WOUND CARE	614	614	24,483	137,243	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,326	3,326	547,033	1,163,389	0	88.00
91.00	09100	EMERGENCY	4,543	4,543	913,858	12,290,860	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	90,504	90,504	8,123,674	77,216,844	-3,181,152	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	470	470	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,750	5,750	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	391	391	68,189	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	455	455	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	1,368	1,368	0	0	0	194.04
194.05	07955	VACANT SPACE	909	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	785,419	657,132	1,514,449	955,511		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.866225	6.641857	0.184872	0.012374		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,317	28,013		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001381	0.000363		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: 14-1342

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

Worksheet B-1

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LBS OF LAU NDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	15,982,113				5.02
7.00	00700	OPERATION OF PLANT	1,204,832	63,473			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,312	1,684	60,337		8.00
9.00	00900	HOUSEKEEPING	423,854	1,287	1,649	59,973	9.00
10.00	01000	DIETARY	631,960	3,180	373	3,180	32,832 10.00
11.00	01100	CAFETERIA	0	0	0	0	9,067 11.00
13.00	01300	NURSING ADMINISTRATION	783,654	2,767	0	2,768	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	162,855	1,964	0	1,964	0 14.00
15.00	01500	PHARMACY	471,200	1,231	0	1,231	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	252,196	1,144	0	1,144	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,646,493	7,130	11,808	7,130	7,332 30.00
46.00	04600	OTHER LONG TERM CARE	959,814	5,941	28,877	5,941	16,433 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	664,107	3,921	3,027	3,921	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
53.00	05300	ANESTHESIOLOGY	283,820	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,473,239	6,313	2,391	6,313	0 54.00
54.01	05401	ULTRASOUND	0	0	0	0	0 54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	1,132,777	1,747	0	1,747	0 60.00
65.00	06500	RESPIRATORY THERAPY	94,265	263	0	263	0 65.00
66.00	06600	PHYSICAL THERAPY	588,443	4,429	4,310	4,429	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	234,729	1,146	0	1,000	0 67.00
68.00	06800	SPEECH PATHOLOGY	114,200	176	0	139	0 68.00
69.00	06900	ELECTROCARDIOLOGY	163,961	759	0	759	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,092	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,314	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	448,862	0	0	0	0 73.00
76.00	03610	SLEEP LAB	106,454	356	0	356	0 76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	282,980	771	0	771	0 76.01
76.03	03950	WOUND CARE	69,080	962	0	614	0 76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	859,869	3,325	474	3,326	0 88.00
91.00	09100	EMERGENCY	2,441,192	4,543	7,428	4,543	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,720,554	55,039	60,337	51,539	32,832 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,819	470	0	470	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	96,276	5,750	0	5,750	0 192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0 194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	125,201	391	0	391	0 194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	6,266	455	0	455	0 194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0 194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	19,847	1,368	0	1,368	0 194.04
194.05	07955	VACANT SPACE	7,150	0	0	0	0 194.05
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,219,779	1,447,559	115,673	541,756	861,239 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.201461	22.805902	1.917116	9.033332	26.231695 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	276,474	229,240	31,668	31,888	70,459 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017299	3.611614	0.524852	0.531706	2.146047 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: 14-1342

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

Worksheet B-1

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (NURSING WA GES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	9,953					11.00
13.00	01300	NURSING ADMINISTRATION	443	2,535,531				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	215	0	541,363			14.00
15.00	01500	PHARMACY	294	0	14,144	378,051		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	229	0	3,116	0	77,216,844	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,836	1,146,368	45,759	0	3,839,092	30.00
46.00	04600	OTHER LONG TERM CARE	1,569	0	11,788	0	720,012	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	551	333,886	70,522	0	4,141,506	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	7,065	0	820,241	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859	0	26,262	0	28,450,402	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	751	0	170,841	0	11,894,313	60.00
65.00	06500	RESPIRATORY THERAPY	121	66,646	1,909	0	368,558	65.00
66.00	06600	PHYSICAL THERAPY	646	0	5,444	0	3,113,954	66.00
67.00	06700	OCCUPATIONAL THERAPY	202	0	507	0	661,898	67.00
68.00	06800	SPEECH PATHOLOGY	90	0	1,682	0	326,346	68.00
69.00	06900	ELECTROCARDIOLOGY	105	74,773	1,515	0	1,434,901	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	75,149	0	802,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,648	0	74,807	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	378,051	6,560,892	73.00
76.00	03610	SLEEP LAB	0	0	3,293	0	322,518	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	92,960	76.01
76.03	03950	WOUND CARE	65	0	2,650	0	137,243	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	645	0	17,230	0	1,163,389	88.00
91.00	09100	EMERGENCY	1,232	913,858	64,839	0	12,290,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,853	2,535,531	541,363	378,051	77,216,844	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07956	AREAS UNDER RENOVATION	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - MARKETING	100	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - SENIOR CIRC	0	0	0	0	0	194.02
194.03	07953	FREESTANDING HHA COSTS	0	0	0	0	0	194.03
194.04	07954	LEASED TO SPECIALTY CLINICS	0	0	0	0	0	194.04
194.05	07955	VACANT SPACE	0	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	199,216	1,038,505	262,499	618,065	345,523	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.015674	0.409581	0.484885	1.634872	0.004475	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,458	66,652	39,920	33,074	26,447	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.637496	0.026287	0.073740	0.087486	0.000343	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,965,824		2,965,824	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,869,105		1,869,105	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,129,054		1,129,054	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	348,096		348,096	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,132,845		2,132,845	0	0	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,567,705		1,567,705	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	153,924	0	153,924	0	0	65.00
66.00	06600	PHYSICAL THERAPY	885,775	0	885,775	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,438	0	324,438	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	146,554	0	146,554	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	261,043		261,043	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	207,146		207,146	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,701		35,701	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,186,715		1,186,715	0	0	73.00
76.00	03610	SLEEP LAB	142,275		142,275	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	364,953		364,953	0	0	76.01
76.03	03950	WOUND CARE	113,682		113,682	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,166,354		1,166,354	0	0	88.00
91.00	09100	EMERGENCY	3,577,289		3,577,289	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	279,642		279,642		0	92.00
200.00		Subtotal (see instructions)	18,858,120	0	18,858,120	0	0	200.00
201.00		Less Observation Beds	279,642		279,642		0	201.00
202.00		Total (see instructions)	18,578,478	0	18,578,478	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XVIII		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,189,208		3,189,208			30.00
46.00	04600	OTHER LONG TERM CARE	720,012		720,012			46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	63,307	4,078,199	4,141,506	0.272619	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	15,422	804,819	820,241	0.424383	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	976,535	27,473,867	28,450,402	0.074967	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,488,671	10,405,642	11,894,313	0.131803	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	219,955	148,603	368,558	0.417638	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	425,943	2,688,011	3,113,954	0.284453	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	371,844	290,054	661,898	0.490163	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	145,609	180,737	326,346	0.449076	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	26,812	1,408,089	1,434,901	0.181924	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	363,254	439,698	802,952	0.257981	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	240	74,567	74,807	0.477241	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,611,714	3,949,178	6,560,892	0.180877	0.000000	73.00
76.00	03610	SLEEP LAB	0	322,518	322,518	0.441138	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	92,960	92,960	3.925914	0.000000	76.01
76.03	03950	WOUND CARE	106	137,137	137,243	0.828326	0.000000	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,163,389	1,163,389			88.00
91.00	09100	EMERGENCY	32,889	12,257,971	12,290,860	0.291053	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,280	646,604	649,884	0.430295	0.000000	92.00
200.00		Subtotal (see instructions)	10,654,801	66,562,043	77,216,844			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,654,801	66,562,043	77,216,844			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03610	SLEEP LAB	0.000000			76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.01
76.03	03950	WOUND CARE	0.000000			76.03
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
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,965,824		2,965,824	0	2,965,824	30.00
46.00	04600	OTHER LONG TERM CARE	1,869,105		1,869,105	0	1,869,105	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,129,054		1,129,054	0	1,129,054	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	348,096		348,096	0	348,096	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,132,845		2,132,845	0	2,132,845	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	1,567,705		1,567,705	0	1,567,705	60.00
65.00	06500	RESPIRATORY THERAPY	153,924	0	153,924	0	153,924	65.00
66.00	06600	PHYSICAL THERAPY	885,775	0	885,775	0	885,775	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,438	0	324,438	0	324,438	67.00
68.00	06800	SPEECH PATHOLOGY	146,554	0	146,554	0	146,554	68.00
69.00	06900	ELECTROCARDIOLOGY	261,043		261,043	0	261,043	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	207,146		207,146	0	207,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,701		35,701	0	35,701	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,186,715		1,186,715	0	1,186,715	73.00
76.00	03610	SLEEP LAB	142,275		142,275	0	142,275	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	364,953		364,953	0	364,953	76.01
76.03	03950	WOUND CARE	113,682		113,682	0	113,682	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,166,354		1,166,354	0	1,166,354	88.00
91.00	09100	EMERGENCY	3,577,289		3,577,289	0	3,577,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	279,642		279,642	0	279,642	92.00
200.00		Subtotal (see instructions)	18,858,120	0	18,858,120	0	18,858,120	200.00
201.00		Less Observation Beds	279,642		279,642	0	279,642	201.00
202.00		Total (see instructions)	18,578,478	0	18,578,478	0	18,578,478	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XIX		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,189,208		3,189,208		30.00	
46.00	04600	OTHER LONG TERM CARE	720,012		720,012		46.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	63,307	4,078,199	4,141,506	0.272619	0.000000	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	
53.00	05300	ANESTHESIOLOGY	15,422	804,819	820,241	0.424383	0.000000	
54.00	05400	RADIOLOGY-DIAGNOSTIC	976,535	27,473,867	28,450,402	0.074967	0.000000	
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	
58.00	05800	MRI	0	0	0	0.000000	0.000000	
60.00	06000	LABORATORY	1,488,671	10,405,642	11,894,313	0.131803	0.000000	
65.00	06500	RESPIRATORY THERAPY	219,955	148,603	368,558	0.417638	0.000000	
66.00	06600	PHYSICAL THERAPY	425,943	2,688,011	3,113,954	0.284453	0.000000	
67.00	06700	OCCUPATIONAL THERAPY	371,844	290,054	661,898	0.490163	0.000000	
68.00	06800	SPEECH PATHOLOGY	145,609	180,737	326,346	0.449076	0.000000	
69.00	06900	ELECTROCARDIOLOGY	26,812	1,408,089	1,434,901	0.181924	0.000000	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	363,254	439,698	802,952	0.257981	0.000000	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	240	74,567	74,807	0.477241	0.000000	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,611,714	3,949,178	6,560,892	0.180877	0.000000	
76.00	03610	SLEEP LAB	0	322,518	322,518	0.441138	0.000000	
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	92,960	92,960	3.925914	0.000000	
76.03	03950	WOUND CARE	106	137,137	137,243	0.828326	0.000000	
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,163,389	1,163,389	1.002549	0.000000	
91.00	09100	EMERGENCY	32,889	12,257,971	12,290,860	0.291053	0.000000	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,280	646,604	649,884	0.430295	0.000000	
200.00		Subtotal (see instructions)	10,654,801	66,562,043	77,216,844			
201.00		Less Observation Beds						
202.00		Total (see instructions)	10,654,801	66,562,043	77,216,844			

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.272619			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
53.00	05300	ANESTHESIOLOGY	0.424383			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074967			54.00
54.01	05401	ULTRASOUND	0.000000			54.01
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.131803			60.00
65.00	06500	RESPIRATORY THERAPY	0.417638			65.00
66.00	06600	PHYSICAL THERAPY	0.284453			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.490163			67.00
68.00	06800	SPEECH PATHOLOGY	0.449076			68.00
69.00	06900	ELECTROCARDIOLOGY	0.181924			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.257981			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.477241			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180877			73.00
76.00	03610	SLEEP LAB	0.441138			76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.925914			76.01
76.03	03950	WOUND CARE	0.828326			76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.002549			88.00
91.00	09100	EMERGENCY	0.291053			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430295			92.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,129,054	104,473	1,024,581	0	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	348,096	6,010	342,086	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,132,845	168,554	1,964,291	0	0
54.01	05401	ULTRASOUND	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	1,567,705	74,988	1,492,717	0	0
65.00	06500	RESPIRATORY THERAPY	153,924	8,980	144,944	0	0
66.00	06600	PHYSICAL THERAPY	885,775	99,226	786,549	0	0
67.00	06700	OCCUPATIONAL THERAPY	324,438	24,307	300,131	0	0
68.00	06800	SPEECH PATHOLOGY	146,554	5,320	141,234	0	0
69.00	06900	ELECTROCARDIOLOGY	261,043	20,358	240,685	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	207,146	8,513	198,633	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,701	1,740	33,961	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,186,715	45,471	1,141,244	0	0
76.00	03610	SLEEP LAB	142,275	8,953	133,322	0	0
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	364,953	19,342	345,611	0	0
76.03	03950	WOUND CARE	113,682	14,335	99,347	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,166,354	81,058	1,085,296	0	0
91.00	09100	EMERGENCY	3,577,289	171,624	3,405,665	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	279,642	21,140	258,502	0	0
200.00		Subtotal (sum of lines 50 thru 199)	14,023,191	884,392	13,138,799	0	0
201.00		Less Observation Beds	279,642	21,140	258,502	0	0
202.00		Total (line 200 minus line 201)	13,743,549	863,252	12,880,297	0	0

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

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			Title XIX		Hospital	PPS
			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
			6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,129,054	4,141,506	0.272619	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	348,096	820,241	0.424383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,132,845	28,450,402	0.074967	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0.000000	58.00
60.00	06000	LABORATORY	1,567,705	11,894,313	0.131803	60.00
65.00	06500	RESPIRATORY THERAPY	153,924	368,558	0.417638	65.00
66.00	06600	PHYSICAL THERAPY	885,775	3,113,954	0.284453	66.00
67.00	06700	OCCUPATIONAL THERAPY	324,438	661,898	0.490163	67.00
68.00	06800	SPEECH PATHOLOGY	146,554	326,346	0.449076	68.00
69.00	06900	ELECTROCARDIOLOGY	261,043	1,434,901	0.181924	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	207,146	802,952	0.257981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,701	74,807	0.477241	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,186,715	6,560,892	0.180877	73.00
76.00	03610	SLEEP LAB	142,275	322,518	0.441138	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	364,953	92,960	3.925914	76.01
76.03	03950	WOUND CARE	113,682	137,243	0.828326	76.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,166,354	1,163,389	1.002549	88.00
91.00	09100	EMERGENCY	3,577,289	12,290,860	0.291053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	279,642	649,884	0.430295	92.00
200.00		Subtotal (sum of lines 50 thru 199)	14,023,191	73,307,624		200.00
201.00		Less Observation Beds	279,642	0		201.00
202.00		Total (line 200 minus line 201)	13,743,549	73,307,624		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

				Title XVIII		Hospital	Cost		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	104,473	4,141,506	0.025226	46,161	1,164	50.00	
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00	
53.00	05300	ANESTHESIOLOGY	6,010	820,241	0.007327	10,358	76	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,554	28,450,402	0.005924	624,219	3,698	54.00	
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00	
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00	
58.00	05800	MRI	0	0	0.000000	0	0	58.00	
60.00	06000	LABORATORY	74,988	11,894,313	0.006305	813,646	5,130	60.00	
65.00	06500	RESPIRATORY THERAPY	8,980	368,558	0.024365	165,007	4,020	65.00	
66.00	06600	PHYSICAL THERAPY	99,226	3,113,954	0.031865	49,005	1,562	66.00	
67.00	06700	OCCUPATIONAL THERAPY	24,307	661,898	0.036723	22,713	834	67.00	
68.00	06800	SPEECH PATHOLOGY	5,320	326,346	0.016302	75,612	1,233	68.00	
69.00	06900	ELECTROCARDIOLOGY	20,358	1,434,901	0.014188	15,564	221	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,513	802,952	0.010602	200,160	2,122	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,740	74,807	0.023260	160	4	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	45,471	6,560,892	0.006931	1,490,255	10,329	73.00	
76.00	03610	SLEEP LAB	8,953	322,518	0.027760	0	0	76.00	
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	19,342	92,960	0.208068	0	0	76.01	
76.03	03950	WOUND CARE	14,335	137,243	0.104450	106	11	76.03	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	81,058	1,163,389	0.069674	0	0	88.00	
91.00	09100	EMERGENCY	171,624	12,290,860	0.013964	22,571	315	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,140	649,884	0.032529	2,177	71	92.00	
200.00		Total (lines 50 through 199)	884,392	73,307,624		3,537,714	30,790	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

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

Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 1:49 pm

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
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	76.03
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)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1342		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/28/2020 1:49 pm	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,141,506	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	820,241	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,450,402	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,894,313	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	368,558	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,113,954	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	661,898	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	326,346	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,434,901	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	802,952	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	74,807	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,560,892	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	322,518	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	92,960	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	137,243	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,163,389	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,290,860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	649,884	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	73,307,624		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Title XVIII			Hospital		Cost	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	46,161	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	10,358	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	624,219	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	813,646	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	165,007	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	49,005	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	22,713	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	75,612	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	15,564	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	200,160	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	160	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,490,255	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	106	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	22,571	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,177	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,537,714	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.272619	0	1,121,502	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.424383	0	230,129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074967	0	9,850,397	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.131803	0	3,517,492	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.417638	0	64,567	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.284453	0	928,101	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.490163	0	71,146	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.449076	0	89,266	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181924	0	563,956	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.257981	0	157,620	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.477241	0	10,805	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180877	0	1,492,735	197	0	73.00
76.00	03610	SLEEP LAB	0.441138	0	109,755	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.925914	0	91,255	0	0	76.01
76.03	03950	WOUND CARE	0.828326	0	81,588	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0			0	88.00
91.00	09100	EMERGENCY	0.291053	0	3,923,903	398	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430295	0	332,465	0	0	92.00
200.00		Subtotal (see instructions)		0	22,636,682	595	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	22,636,682	595	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XVIII		Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	305,743	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	97,663	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	738,455	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	463,616	0		60.00
65.00	06500	RESPIRATORY THERAPY	26,966	0		65.00
66.00	06600	PHYSICAL THERAPY	264,001	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	34,873	0		67.00
68.00	06800	SPEECH PATHOLOGY	40,087	0		68.00
69.00	06900	ELECTROCARDIOLOGY	102,597	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,663	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,157	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	270,001	36		73.00
76.00	03610	SLEEP LAB	48,417	0		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	358,259	0		76.01
76.03	03950	WOUND CARE	67,581	0		76.03
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	1,142,064	116		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	143,058	0		92.00
200.00		Subtotal (see instructions)	4,149,201	152		200.00
201.00		Less PBP Clinic Lab. Services-Program	0			201.00
		Only Charges				
202.00		Net Charges (line 200 - line 201)	4,149,201	152		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:

Worksheet D

From 01/01/2019

Part IV

Component CCN: 14-Z342

To 12/31/2019

Date/Time Prepared:

8/28/2020 1:49 pm

Cost Center Description		Title XVIII		Swing Beds - SNF		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
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	76.03
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)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Component CCN: 14-Z342

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

Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description			Title XVIII		Swing Beds - SNF		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) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,141,506	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	820,241	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,450,402	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,894,313	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	368,558	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,113,954	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	661,898	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	326,346	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,434,901	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	802,952	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	74,807	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,560,892	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	322,518	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	92,960	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	137,243	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,163,389	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,290,860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	649,884	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	73,307,624		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:

Worksheet D

Component CCN: 14-Z342

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

Part IV
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Title XVIII		Swing Beds - SNF		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	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	26,431	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	154,004	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	12,299	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	245,513	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	255,016	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	36,465	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,386	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	54,958	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	277,464	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,063,536	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1342

Period:

Worksheet D

Component CCN: 14-Z342

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XVIII	Swing Beds - SNF	Cost			
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.272619	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.424383	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.074967	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.131803	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.417638	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.284453	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.490163	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.449076	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181924	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.257981	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.477241	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.180877	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0.441138	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.925914	0	0	0	0	76.01
76.03	03950	WOUND CARE	0.828326	0	0	0	0	76.03
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.291053	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.430295	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			0	0		201.00
		Only Charges						
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: 14-1342

Period:

Worksheet D

Component CCN: 14-Z342

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XVIII		Swing Beds - SNF		Cost		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0					50.00
51.00	05100	RECOVERY ROOM	0	0					51.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
54.01	05401	ULTRASOUND	0	0					54.01
56.00	05600	RADIOISOTOPE	0	0					56.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03610	SLEEP LAB	0	0					76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0					76.01
76.03	03950	WOUND CARE	0	0					76.03
	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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	224,211	0	224,211	1,838	121.99	30.00
200.00	Total (lines 30 through 199)	224,211		224,211	1,838		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	28	3,416				
200.00	Total (lines 30 through 199)	28	3,416				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	104,473	4,141,506	0.025226	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	6,010	820,241	0.007327	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	168,554	28,450,402	0.005924	0	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0	58.00
60.00	06000	LABORATORY	74,988	11,894,313	0.006305	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,980	368,558	0.024365	0	65.00
66.00	06600	PHYSICAL THERAPY	99,226	3,113,954	0.031865	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	24,307	661,898	0.036723	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,320	326,346	0.016302	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,358	1,434,901	0.014188	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,513	802,952	0.010602	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,740	74,807	0.023260	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,471	6,560,892	0.006931	0	73.00
76.00	03610	SLEEP LAB	8,953	322,518	0.027760	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	19,342	92,960	0.208068	0	76.01
76.03	03950	WOUND CARE	14,335	137,243	0.104450	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	81,058	1,163,389	0.069674	0	88.00
91.00	09100	EMERGENCY	171,624	12,290,860	0.013964	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	29,399	649,884	0.045237	0	92.00
200.00		Total (lines 50 through 199)	892,651	73,307,624		0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-1342		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 8/28/2020 1:49 pm		
					Title XIX		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	1,838	0.00	28	30.00			
200.00		Total (lines 30 through 199)	0	0	1,838		28	200.00			
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

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

Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03610	SLEEP LAB	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.03	03950	WOUND CARE	0	0	0	0	76.03
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)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 1:49 pm

			Title XIX		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,141,506	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	820,241	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,450,402	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	11,894,313	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	368,558	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,113,954	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	661,898	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	326,346	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,434,901	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	802,952	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	74,807	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,560,892	0.000000	73.00
76.00	03610	SLEEP LAB	0	0	0	322,518	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	92,960	0.000000	76.01
76.03	03950	WOUND CARE	0	0	0	137,243	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,163,389	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	12,290,860	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	649,884	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	73,307,624		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
76.00	03610	SLEEP LAB	0.000000	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	76.01
76.03	03950	WOUND CARE	0.000000	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 1:49 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,556	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,838	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)		1,597	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		718	5.00	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00	
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,006	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)		525	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		0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions)		2,965,824	21.00	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00	
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00	
26.00	Total swing-bed cost (see instructions)		833,124	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,132,700	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)		2,132,700	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)		1,160.34	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,167,302	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,167,302	41.00	

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 1:49 pm
			Title XVIII	Hospital	Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					630,650 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,797,952 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)					609,179 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)					609,179 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)					241 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,160.34 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					279,642 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Title XVIII		Hospital		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	224,211	2,965,824	0.075598	279,642	21,140	90.00
91.00	Nursing School cost	0	2,965,824	0.000000	279,642	0	91.00
92.00	Allied health cost	0	2,965,824	0.000000	279,642	0	92.00
93.00	All other Medical Education	0	2,965,824	0.000000	279,642	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/28/2020 1:49 pm	
Cost Center Description		Title XIX	Hospital	PPS	
PART I - ALL PROVIDER COMPONENTS				1.00	
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,556	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,838	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)			1,597	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			28	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				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			0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,965,824	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,965,824	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)			2,965,824	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)			1,613.61	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			45,181	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)			45,181	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Title XIX		Hospital	PPS		
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					45,181	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)					3,416	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)					3,416	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					41,765	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					241	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,613.61	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					388,880	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1342

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

Worksheet D-1

Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	224,211	2,965,824	0.075598	388,880	29,399
91.00	Nursing School cost	0	2,965,824	0.000000	388,880	0
92.00	Allied health cost	0	2,965,824	0.000000	388,880	0
93.00	All other Medical Education	0	2,965,824	0.000000	388,880	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/28/2020 1:49 pm	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,517,566		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.272619	46,161	12,584	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.424383	10,358	4,396	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.074967	624,219	46,796	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.131803	813,646	107,241	60.00
65.00	06500 RESPIRATORY THERAPY	0.417638	165,007	68,913	65.00
66.00	06600 PHYSICAL THERAPY	0.284453	49,005	13,940	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.490163	22,713	11,133	67.00
68.00	06800 SPEECH PATHOLOGY	0.449076	75,612	33,956	68.00
69.00	06900 ELECTROCARDIOLOGY	0.181924	15,564	2,831	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.257981	200,160	51,637	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.477241	160	76	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.180877	1,490,255	269,553	73.00
76.00	03610 SLEEP LAB	0.441138	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.925914	0	0	76.01
76.03	03950 WOUND CARE	0.828326	106	88	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.291053	22,571	6,569	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.430295	2,177	937	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,537,714	630,650	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)		3,537,714		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1342 Component CCN: 14-Z342	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/28/2020 1:49 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.272619	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.424383	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.074967	26,431	1,981	54.00
54.01	05401 ULTRASOUND	0.000000	0	0	54.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.131803	154,004	20,298	60.00
65.00	06500 RESPIRATORY THERAPY	0.417638	12,299	5,137	65.00
66.00	06600 PHYSICAL THERAPY	0.284453	245,513	69,837	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.490163	255,016	124,999	67.00
68.00	06800 SPEECH PATHOLOGY	0.449076	36,465	16,376	68.00
69.00	06900 ELECTROCARDIOLOGY	0.181924	1,386	252	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.257981	54,958	14,178	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.477241	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.180877	277,464	50,187	73.00
76.00	03610 SLEEP LAB	0.441138	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3.925914	0	0	76.01
76.03	03950 WOUND CARE	0.828326	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.291053	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.430295	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,063,536	303,245	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,063,536		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/28/2020 1:49 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,149,353	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)		4,149,353	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)		4,190,847	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)		62,187	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,783,702	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)		344,958	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)		344,958	30.00
31.00	Primary payer payments		374	31.00
32.00	Subtotal (line 30 minus line 31)		344,584	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)		1,059,950	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		688,968	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,037,647	36.00
37.00	Subtotal (see instructions)		1,033,552	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,033,552	40.00
40.01	Sequestration adjustment (see instructions)		20,671	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		651,040	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		361,841	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/28/2020 1:49 pm

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,343,879		651,040	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	08/20/2019	44,000		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		44,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,387,879		651,040	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		160,621		361,841	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,548,500		1,012,881	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: 14-1342

Period:

Worksheet E-1

Component CCN: 14-Z342

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/28/2020 1:49 pm

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		787,336		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		787,336		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		100,075		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		887,411		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: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/28/2020 1:49 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet E-2
		Component CCN: 14-Z342		Date/Time Prepared: 8/28/2020 1:49 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		615,271	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		306,277	0
3.01	Nursing and allied health payment-PARHM (see instructions)			0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		525	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		921,548	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		921,548	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		921,548	0
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		16,027	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (see instructions)		905,521	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0	0
16.99	Demonstration payment adjustment amount before sequestration		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		905,521	0
19.01	Sequestration adjustment (see instructions)		18,110	0
19.02	Demonstration payment adjustment amount after sequestration)		0	0
19.03	Sequestration adjustment-PARHM pass-throughs			0
20.00	Interim payments		787,336	0
20.01	Interim payments-PARHM			0
21.00	Tentative settlement (for contractor use only)		0	0
21.01	Tentative settlement-PARHM (for contractor use only)			0
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		100,075	0
22.01	Balance due provider/program-PARHM (see instructions)			0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0
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: 14-1342	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 8/28/2020 1:49 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		1,797,952	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)		1,797,952	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,815,932	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)		1,815,932	19.00
20.00	Deductibles (exclude professional component)		267,248	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,548,684	22.00
23.00	Coinsurance		4,774	23.00
24.00	Subtotal (line 22 minus line 23)		1,543,910	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		55,680	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		36,192	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		54,364	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,580,102	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)		1,580,102	30.00
30.01	Sequestration adjustment (see instructions)		31,602	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		1,387,879	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		160,621	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
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: 14-1342

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

Worksheet G

Date/Time Prepared:
8/28/2020 1:49 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	16,301	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	6,632,714	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,811,591	0	0	0	6.00
7.00	Inventory	411,842	0	0	0	7.00
8.00	Prepaid expenses	231,667	0	0	0	8.00
9.00	Other current assets	11,314	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,492,247	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	135,853	0	0	0	13.00
14.00	Accumulated depreciation	-36,288	0	0	0	14.00
15.00	Buildings	3,304,483	0	0	0	15.00
16.00	Accumulated depreciation	-2,131,840	0	0	0	16.00
17.00	Leasehold improvements	10,105,960	0	0	0	17.00
18.00	Accumulated depreciation	-4,653,939	0	0	0	18.00
19.00	Fixed equipment	1,484,146	0	0	0	19.00
20.00	Accumulated depreciation	-750,367	0	0	0	20.00
21.00	Automobiles and trucks	57,058	0	0	0	21.00
22.00	Accumulated depreciation	-57,058	0	0	0	22.00
23.00	Major movable equipment	5,061,626	0	0	0	23.00
24.00	Accumulated depreciation	-3,844,207	0	0	0	24.00
25.00	Minor equipment depreciable	3,359,700	0	0	0	25.00
26.00	Accumulated depreciation	-3,150,354	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,884,773	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	255,268	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,278,819	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,534,087	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,911,107	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,357,063	0	0	0	37.00
38.00	Salaries, wages, and fees payable	629,501	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	-10,736,367	0	0	0	43.00
44.00	Other current liabilities	97,016	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-8,652,787	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	256,095	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	256,095	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-8,396,692	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,307,799				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)	24,307,799	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,911,107	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1342

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

Worksheet G-1

Date/Time Prepared:
8/28/2020 1:49 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		23,546,309		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		761,490				2.00
3.00	Total (sum of line 1 and line 2)		24,307,799		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,307,799		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)		24,307,799		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1342

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/28/2020 1:49 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,189,208		3,189,208	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	720,012		720,012	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,909,220		3,909,220	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)	3,909,220		3,909,220	17.00
18.00	Ancillary services	6,745,581	52,494,079	59,239,660	18.00
19.00	Outpatient services	0	12,904,575	12,904,575	19.00
20.00	RURAL HEALTH CLINIC	0	1,163,389	1,163,389	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,654,801	66,562,043	77,216,844	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,964,287		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,964,287		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1342

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

Worksheet G-3

Date/Time Prepared:
8/28/2020 1:49 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	77,216,844	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,043,447	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,173,397	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,964,287	4.00
5.00	Net income from service to patients (line 3 minus line 4)	209,110	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	335,000	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	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	38,627	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	185	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	15,756	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	6,407	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC OTHER REVENUE	156,405	24.00
25.00	Total other income (sum of lines 6-24)	552,380	25.00
26.00	Total (line 5 plus line 25)	761,490	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	761,490	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342

Period:

Worksheet M-1

Component CCN: 14-3975

From 01/01/2019

Date/Time Prepared:

To 12/31/2019

8/28/2020 1:49 pm

		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	0	0	0	0	1.00
2.00	Physician Assistant	340,038	0	340,038	0	2.00
3.00	Nurse Practitioner	25,917	0	25,917	0	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	181,078	0	181,078	0	5.00
6.00	Clinical Psychologist	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	547,033	0	547,033	0	10.00
11.00	Physician Services Under Agreement	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	77,800	77,800	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	77,800	77,800	0	14.00
15.00	Medical Supplies	0	17,230	17,230	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	17,230	17,230	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	547,033	95,030	642,063	0	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	23.00
24.00	Dental	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	388	388	0	29.00
30.00	Administrative Costs	57,430	369,824	427,254	-58,568	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	57,430	370,212	427,642	-58,568	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	604,463	465,242	1,069,705	-58,568	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1342

Period:

Worksheet M-1

Component CCN: 14-3975

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/28/2020 1:49 pm

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0	1.00	
2.00	Physician Assistant	0	340,038	2.00	
3.00	Nurse Practitioner	0	25,917	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	181,078	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	0	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	547,033	10.00	
11.00	Physician Services Under Agreement	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	77,800	12.00	
13.00	Other Costs Under Agreement	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	77,800	14.00	
15.00	Medical Supplies	0	17,230	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	17,230	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	642,063	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	388	29.00	
30.00	Administrative Costs	-315,049	53,637	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	-315,049	54,025	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	-315,049	696,088	32.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1342

Period:

Worksheet M-2

Component CCN: 14-3975

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/28/2020 1:49 pm

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	2.88	7,948	2,100	6,048		2.00
3.00	Nurse Practitioner	0.19	534	2,100	399		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.07	8,482		6,447	8,482	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.07	8,482			8,482	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)					642,063	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					642,063	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					54,025	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					470,266	15.00
16.00	Total overhead (sum of lines 14 and 15)					524,291	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					524,291	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					524,291	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,166,354	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1342 Component CCN: 14-3975	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/28/2020 1:49 pm		
		Title XVIII	RHC I	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,166,354	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			7,364	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,158,990	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			8,482	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			8,482	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			136.64	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			0.00	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			136.64	136.64	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	1,014	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	138,553	11.00
12.00	Program covered visits for mental health services (from contractor records)			0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)			0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)			0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	138,553	16.00
16.01	Total program charges (see instructions)(from contractor's records)				146,501	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)				91,711	16.04
16.05	Total program cost (see instructions)			0	91,711	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				23,914	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				24,517	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				91,711	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				2,545	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				94,256	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)				94,256	26.00
26.01	Sequestration adjustment (see instructions)				1,885	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				109,763	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)				-17,392	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: 14-1342 Component CCN: 14-3975	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 8/28/2020 1:49 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		547,033	547,033	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.002397	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	1,311	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	2,743	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	4,054	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		642,063	642,063	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		524,291	524,291	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.006314	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	3,310	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	7,364	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	81	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	90.91	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	28	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	2,545	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)			7,364	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			2,545	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1342 Component CCN: 14-3975	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/28/2020 1:49 pm	
			RHC I	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			109,763	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			109,763	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			17,392	6.02
7.00	Total Medicare program liability (see instructions)			92,371	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00