

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: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 8/26/2020 3:56 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/26/2020	Time: 3:56 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 FAYETTE COUNTY HOSPITAL (14-1346) 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) GREG STARNES

Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	53,507	161,578	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	103,041	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		678		0	10.00
10.01	RURAL HEALTH CLINIC II	0		12,209		0	10.01
200.00	Total	0	156,548	174,465	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: 14-1346		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 3:56 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: SEVENTH & TAYLOR			PO Box:				1.00				
2.00	City: VANDALIA			State: IL		Zip Code: 62471-		County: FAYETTE				
		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			FAYETTE COUNTY HOSPITAL	141346	99914	1	04/01/2005	N	O	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			FAYETTE COUNTY SNF	142346	99914		04/01/2005	N	O	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF			FAYETTE COUNTY SNF	145499	99914		07/01/1983	N	P	O	9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC			VANDALIA	148527	99914		06/01/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II			ST ELMO	148528	99914		06/01/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019		20.00		
21.00	Type of Control (see instructions)						2			21.00		
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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		

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1346

Period:
From 01/01/2019
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Date/Time Prepared:
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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		
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural S	Date of Geogr		
					1.00	2.00		
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2						26.00	
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27.00	
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:		
					1.00	2.00		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0						37.00	
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
					Y/N	Y/N		
					1.00	2.00		
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N					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	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals								
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no 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							56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.								58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N							59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 01/01/2019
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

Worksheet S-2
Part I
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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.			N 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 Y 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 Y 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.			N N 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.			N N 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.			N 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 Y 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 Y 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.			N N 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.			N 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.			N 108.00			
			Physical	Occupational	Speech	Respiratory	
			1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N
			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			

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
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		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	120,699	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	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.	Y	44.00	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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1346		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 8/26/2020 3:56 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
							Beginning	Ending	
							1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
							1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1346		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part II Date/Time Prepared: 8/26/2020 3:56 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
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)			Y	03/25/2020	Y	03/25/2020
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	18.00
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	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part II
Date/Time Prepared:
8/26/2020 3:56 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SHAWN	ADAMS		41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & COMPANY LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-992-3500	SADAMS@BLUEANDCO.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1346

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.	SENIOR 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: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 3:56 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	39,936.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	39,936.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	504.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	40,440.00	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	44.00	85	31,025		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		110				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: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 3:56 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)	1,166	28	1,664			1.00
2.00 HMO and other (see instructions)	98	120				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	1,596	0	1,596			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	152			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,762	28	3,412			7.00
8.00 INTENSIVE CARE UNIT	20	0	21			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)	2,782	28	3,433	0.00	182.65	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	0	10,349	16,902	0.00	38.86	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	1,792	0	7,819	0.00	11.38	26.00
26.01 RURAL HEALTH CLINIC II	368	0	1,316	0.00	1.12	26.01
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	234.01	27.00
28.00 Observation Bed Days		7	373			28.00
29.00 Ambulance Trips	1					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: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
8/26/2020 3:56 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	327	8	478	1.00
2.00 HMO and other (see instructions)			27	35		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	327	8	478	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	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1346
 Component CCN: 14-8527

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

Worksheet S-8

 Date/Time Prepared:
 8/26/2020 3:56 pm

		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		1442 N 8TH STREET, SUITE C		1.00
	City		State	ZIP Code	
	1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		VANDALIA IL 62471		2.00
					1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
			Grant Award		Date
			1.00		2.00
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
					1.00 2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0 10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00 5.00
Facility hours of operations (1)					
11.00	CLINIC		07:00	17:00	07:00 11.00
					1.00 2.00
12.00	Have you received an approval for an exception to the productivity standard?			N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0 13.00
			Provider name		CCN number
			1.00		2.00
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits			
		5.00			
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				
		County			
		4.00			
2.00	City, State, ZIP Code, County		FAYETTE		
		Tuesday	Wednesday		Thursday
		to	from	to	from to
		6.00	7.00	8.00	9.00 10.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	07:00	17:00	07:00 17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1346

Period:

Worksheet S-8

Component CCN: 14-8527

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 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	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1346
 Component CCN: 14-8528

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

Worksheet S-8

 Date/Time Prepared:
 8/26/2020 3:56 pm

		RHC II		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street		428 N MAIN STREET		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		SAINT ELMO IL 62458		2.00
		1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)				4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				6.00
7.00	Appalachian Regional Commission				7.00
8.00	Look-Alikes				8.00
9.00	OTHER (SPECIFY)				9.00
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N 0		10.00
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1)		CLINIC		11.00
		08:00		12:00	
		08:00		11.00	
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N 0		13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number				14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00
		County		4.00	
2.00	City, State, ZIP Code, County		FAYETTE		2.00
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		10.00		11.00	
11.00	Facility hours of operations (1)		CLINIC		11.00
		12:00	13:00	17:00	08:00
		12:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1346

Period:

Worksheet S-8

Component CCN: 14-8528

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 pm

RHC II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1346

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

Worksheet S-10

Date/Time Prepared:
8/26/2020 3:56 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)		0.376408	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		10,672,246	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		835,242	5.00
6.00	Medicaid charges		13,141,460	6.00
7.00	Medicaid cost (line 1 times line 6)		4,946,551	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,884,963	0	1,884,963
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	709,515	0	709,515
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	709,515	0	709,515
			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)		2,679,102	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		642,181	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		987,971	27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,691,131	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		982,345	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,691,860	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,691,860	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES					Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet A	Date/Time Prepared: 8/26/2020 3:56 pm
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		143,658	143,658	49,395	193,053	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		449,424	449,424	18,845	468,269	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	89,411	3,023,213	3,112,624	7,718	3,120,342	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,022,007	3,506,169	4,528,176	65,840	4,594,016	5.00
7.00	00700	OPERATION OF PLANT	244,266	90,286	334,552	16,333	350,885	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	607,504	607,504	0	607,504	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	12,278	12,278	0	12,278	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	90,369	42,909	133,278	0	133,278	8.00
9.00	00900	HOUSEKEEPING	413,549	112,346	525,895	0	525,895	9.00
10.00	01000	DIETARY	337,017	403,518	740,535	-204,889	535,646	10.00
11.00	01100	CAFETERIA	0	0	0	204,889	204,889	11.00
13.00	01300	NURSING ADMINISTRATION	139,552	16,043	155,595	0	155,595	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,488	600,303	657,791	-531,858	125,933	14.00
15.00	01500	PHARMACY	201,137	1,806,799	2,007,936	-1,326,421	681,515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	387,344	193,303	580,647	0	580,647	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,124,374	200,114	1,324,488	-33,977	1,290,511	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	20,793	20,793	31.00
44.00	04400	SKILLED NURSING FACILITY	1,557,638	424,667	1,982,305	0	1,982,305	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	640,766	498,115	1,138,881	-85,316	1,053,565	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	425,863	859,247	1,285,110	-178,997	1,106,113	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	140,514	140,514	174,670	315,184	55.00
60.00	06000	LABORATORY	729,135	1,000,014	1,729,149	-253	1,728,896	60.00
65.00	06500	RESPIRATORY THERAPY	155,889	104,537	260,426	-27,093	233,333	65.00
66.00	06600	PHYSICAL THERAPY	503,892	59,395	563,287	0	563,287	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,801	5,645	84,446	0	84,446	67.00
68.00	06800	SPEECH PATHOLOGY	85,306	6,181	91,487	0	91,487	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	328,939	328,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	253,168	253,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,351,986	1,351,986	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	846,080	129,570	975,650	0	975,650	88.00
88.01	08801	RURAL HEALTH CLINIC II	124,687	70,295	194,982	0	194,982	88.01
90.00	09000	CLINIC	0	598,291	598,291	0	598,291	90.00
90.01	09002	WOUND CARE	22,283	160,925	183,208	0	183,208	90.01
90.02	09003	PAIN MANAGEMENT	0	155,612	155,612	26,787	182,399	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	373,231	30,174	403,405	93,630	497,035	90.04
90.05	09005	DR BLASER	591,816	39,168	630,984	63,862	694,846	90.05
90.06	09006	DR. RONHOLM	0	86,661	86,661	33,095	119,756	90.06
90.07	09007	DR. BARKOVIK	0	99,612	99,612	28,479	128,091	90.07
90.08	04950	NP LANGSTON	114,388	9,271	123,659	0	123,659	90.08
90.09	09008	OP NURSING SERVICE	0	0	0	69,612	69,612	90.09
90.10	09009	DR. RAJU	0	0	0	42,417	42,417	90.10
91.00	09100	EMERGENCY	1,043,161	1,934,043	2,977,204	11,184	2,988,388	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	12,116	3,282	15,398	-10,177	5,221	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,411,566	17,623,086	29,034,652	462,661	29,497,313	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,023,593	234,052	1,257,645	-312,211	945,434	192.00
192.01	19201	FAYETTE COUNTY ANNEX	51,023	99,427	150,450	-150,450	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	12,486,182	17,956,565	30,442,747	0	30,442,747	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1346

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

Worksheet A

Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	963,147	1,156,200	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-93,294	374,975	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,432,156	4,552,498	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-404,529	4,189,487	5.00
7.00	00700	OPERATION OF PLANT	27,701	378,586	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	607,504	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	12,278	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	133,278	8.00
9.00	00900	HOUSEKEEPING	0	525,895	9.00
10.00	01000	DIETARY	0	535,646	10.00
11.00	01100	CAFETERIA	-89,493	115,396	11.00
13.00	01300	NURSING ADMINISTRATION	0	155,595	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	125,933	14.00
15.00	01500	PHARMACY	-556,119	125,396	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18	580,629	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-24,056	1,266,455	30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,793	31.00
44.00	04400	SKILLED NURSING FACILITY	-639,366	1,342,939	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-248,500	805,065	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-50	1,106,063	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	315,184	55.00
60.00	06000	LABORATORY	-90	1,728,806	60.00
65.00	06500	RESPIRATORY THERAPY	-28,187	205,146	65.00
66.00	06600	PHYSICAL THERAPY	0	563,287	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	84,446	67.00
68.00	06800	SPEECH PATHOLOGY	0	91,487	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	328,939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	253,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,351,986	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-758	974,892	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	194,982	88.01
90.00	09000	CLINIC	0	598,291	90.00
90.01	09002	WOUND CARE	-27,061	156,147	90.01
90.02	09003	PAIN MANAGEMENT	-155,000	27,399	90.02
90.03	09001	NEUROLOGY	0	0	90.03
90.04	09004	DR SKOW	-299,996	197,039	90.04
90.05	09005	DR BLASER	-612,346	82,500	90.05
90.06	09006	DR. RONHOLM	-86,011	33,745	90.06
90.07	09007	DR. BARKOVIK	-99,009	29,082	90.07
90.08	04950	NP LANGSTON	-114,388	9,271	90.08
90.09	09008	OP NURSING SERVICE	0	69,612	90.09
90.10	09009	DR. RAJU	-28,281	14,136	90.10
91.00	09100	EMERGENCY	-931,337	2,057,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	5,221	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,014,885	27,482,428	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	945,434	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,014,885	28,427,862	200.00

RECLASSIFICATIONS

Provider CCN: 14-1346

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

Worksheet A-6

Date/Time Prepared:
8/26/2020 3:56 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	93,245	111,644		1.00
	0		93,245	111,644		
	C - EMERGENCY ROOM					
1.00	EMERGENCY	91.00	10,177	0		1.00
	0		10,177	0		
	D - AUTO INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	18,845		1.00
	0		0	18,845		
	E - OCCUPATIONAL HEALTH					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	9,762	2,135		1.00
	0		9,762	2,135		
	F - WELLNESS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	68,240		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	51,023	14,817		2.00
3.00	OPERATION OF PLANT	7.00	0	16,333		3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	35		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	2		5.00
	0		51,023	99,427		
	G - MEDICAL SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	582,072		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
	0		0	582,072		
	H - SCU					
1.00	INTENSIVE CARE UNIT	31.00	17,721	3,072		1.00
	0		17,721	3,072		
	I - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,351,984		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
	0		0	1,351,984		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	253,168		1.00
	0		0	253,168		
	O - SPECIALTY CLINIC RECLASS					
1.00	PAIN MANAGEMENT	90.02	22,959	3,828		1.00
2.00	DR SKOW	90.04	90,536	15,094		2.00
3.00	DR BLASER	90.05	54,736	9,126		3.00
4.00	DR. RONHOLM	90.06	28,403	4,736		4.00
5.00	DR. BARKOVIK	90.07	24,409	4,070		5.00
6.00	DR. RAJU	90.10	12,116	2,020		6.00
	0		233,159	38,874		
	P - PROVIDER BASED RECLASS					
1.00	DR. RAJU	90.10	0	28,281		1.00
	0		0	28,281		
	Q - OP NURSING SERVICE					
1.00	OP NURSING SERVICE	90.09	61,000	8,612		1.00
	TOTALS		61,000	8,612		
	R - RADIOLOGY ADMINISTRATION					
1.00	RADIOLOGY-THERAPEUTIC	55.00	94,779	81,990		1.00
	TOTALS		94,779	81,990		
	S - MEDICAL DIRECTOR RECLASS					
1.00	EMERGENCY	91.00	12,000	0		1.00
	TOTALS		12,000	0		
500.00	Grand Total: Increases		582,866	2,580,104		500.00

8/26/2020 3:56 pm

RECLASSIFICATIONS

Provider CCN: 14-1346

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

Worksheet A-6

Date/Time Prepared:
8/26/2020 3:56 pm

	Decreases							8/26/2020 3:36 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA							
1.00	DIETARY	10.00	93,245	111,644	0			1.00
	0		93,245	111,644				
	C - EMERGENCY ROOM							
1.00	AMBULANCE SERVICES	95.00	10,177	0	0			1.00
	0		10,177	0				
	D - AUTO INSURANCE							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	18,845	12			1.00
	0		0	18,845				
	E - OCCUPATIONAL HEALTH							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	9,762	2,135	0			1.00
	0		9,762	2,135				
	F - WELLNESS							
1.00	FAYETTE COUNTY ANNEX	192.01	51,023	99,427	10			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
	0		51,023	99,427				
	G - MEDICAL SUPPLY							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	531,858	0			1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2,690	0			2.00
3.00	OPERATING ROOM	50.00	0	13,275	0			3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,914	0			4.00
5.00	LABORATORY	60.00	0	253	0			5.00
6.00	RESPIRATORY THERAPY	65.00	0	27,084	0			6.00
7.00	EMERGENCY	91.00	0	4,998	0			7.00
	0		0	582,072				
	H - SCU							
1.00	ADULTS & PEDIATRICS	30.00	17,721	3,072	0			1.00
	0		17,721	3,072				
	I - DRUGS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,179	0			1.00
2.00	PHARMACY	15.00	0	1,326,421	0			2.00
3.00	ADULTS & PEDIATRICS	30.00	0	10,494	0			3.00
4.00	OPERATING ROOM	50.00	0	2,429	0			4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	314	0			5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,099	0			6.00
7.00	RESPIRATORY THERAPY	65.00	0	9	0			7.00
8.00	DR. RONHOLM	90.06	0	44	0			8.00
9.00	EMERGENCY	91.00	0	5,995	0			9.00
	0		0	1,351,984				
	K - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	253,168	0			1.00
	0		0	253,168				
	O - SPECIALTY CLINIC RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	233,159	38,874	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00		0.00	0	0	0			6.00
	0		233,159	38,874				
	P - PROVIDER BASED RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28,281	0			1.00
	0		0	28,281				
	Q - OP NURSING SERVICE							
1.00	OPERATING ROOM	50.00	61,000	8,612	0			1.00
	TOTALS		61,000	8,612				
	R - RADIOLOGY ADMINISTRATION							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	94,779	81,990	0			1.00
	TOTALS		94,779	81,990				
	S - MEDICAL DIRECTOR RECLASS							
1.00	DR SKOW	90.04	12,000	0	0			1.00
	TOTALS		12,000	0				
500.00	Grand Total: Decreases		582,866	2,580,104				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
8/26/2020 3:56 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	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	6,445,698	0	0	0	171,594	6.00	
7.00	HIT designated Assets	1,898,111	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	8,343,809	0	0	0	171,594	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	8,343,809	0	0	0	171,594	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	0	0					2.00
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	6,274,104	0					6.00
7.00	HIT designated Assets	1,898,111	0					7.00
8.00	Subtotal (sum of lines 1-7)	8,172,215	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	8,172,215	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	143,658	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	449,424	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	449,424	0	0	143,658	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	143,658				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	449,424				2.00
3.00	Total (sum of lines 1-2)	0	593,082				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,172,215	0	8,172,215	1.000000	0	2.00
3.00	Total (sum of lines 1-2)	8,172,215	0	8,172,215	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	963,147	68,240	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	356,130	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,319,277	68,240	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	124,813	0	0	1,156,200	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	18,845	0	0	374,975	2.00
3.00	Total (sum of lines 1-2)	0	143,658	0	0	1,531,175	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1346

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

Worksheet A-8

Date/Time Prepared:
8/26/2020 3:56 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-43,350	ADMINISTRATIVE & GENERAL	5.00	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	-1,601	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,368,935			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	2,218,950			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-89,493	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	-18	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines	B	-1,266	OPERATION OF PLANT	7.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0 RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0 PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0 *** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** 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

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ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1346

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

Worksheet A-8

Date/Time Prepared:
8/26/2020 3:56 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	
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	A	-93,294	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISC EMPLOYEE BENEFIT REVENUE	B	-514	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	RADIOLOGY MISC INCOME	B	-50	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	LABORATORY MISC INCOME	B	-90	LABORATORY	60.00	0	33.02
33.03	DR FUNNEMAN MISC REVENUE	B	-758	RURAL HEALTH CLINIC	88.00	0	33.03
33.04	DR SKOW MISC REVENUE	B	-28	DR SKOW	90.04	0	33.04
33.07	DR BLASER MISC REVENUE	B	-242	DR BLASER	90.05	0	33.07
34.00	DR RONHOLM MISC REVENUE	B	-6	DR. RONHOLM	90.06	0	34.00
34.01	DR. BARKOVIK MISC REVENUE	B	-9	DR. BARKOVIK	90.07	0	34.01
34.02	ER MISC REVENUE	B	-573	EMERGENCY	91.00	0	34.02
34.03	AHA LOBBYING DUES PERCENTAGE	A	-3,287	ADMINISTRATIVE & GENERAL	5.00	0	34.03
34.04	IHA LOBBYING DUES PERCENTAGE	A	-9,500	ADMINISTRATIVE & GENERAL	5.00	0	34.04
34.05	340B EXPENSE OFFSET	A	-556,119	PHARMACY	15.00	0	34.05
34.06	OTHER INCOME - SNF TAX REVENUE	B	-492,000	SKILLED NURSING FACILITY	44.00	0	34.06
34.07	LTC MEDICAID ASSESSMENT	A	-147,366	SKILLED NURSING FACILITY	44.00	0	34.07
34.08	MARKETING EXPENSE	A	-37,923	ADMINISTRATIVE & GENERAL	5.00	0	34.08
34.09	CRNA EXPENSE OFFSET	A	-248,500	OPERATING ROOM	50.00	0	34.09
34.10	NURSE PRACTITIONER SALARY	A	-114,388	NP LANGSTON	90.08	0	34.10
34.11	NURSE PRACTITIONER BENEFITS	A	-24,525	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,014,885				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: 14-1346

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

Worksheet A-8-1

Date/Time Prepared:
8/26/2020 3:56 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	54.00	RADIOLOGY-DIAGNOSTIC	DIAGNOSTIC SHARED SERVICES	213,826	213,826	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	BLUEGRASS LEASING	50,509	50,509	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	CONSULTING SERVICES	4,875	4,875	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	CONSULTING SERVICES	35,286	35,286	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	FACILITY MANAGEMENT SERVICES	371,807	371,807	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	GROUP PURCHASING	3,510	3,510	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	BUILDING RENT	17,175	17,175	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	FAYETTE COUNTY DISTRICT	0	1,021,500	3.05
3.06	1.00	NEW CAP REL COSTS-BLDG & FIX	FAYETTE COUNTY DISTRICT	963,147	0	3.06
3.07	60.00	LABORATORY	LAB SAMPLE PROCESSING	98,386	98,386	3.07
3.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	SARAH BUSH LINCOLN	1,457,195	0	3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	SARAH BUSH LINCOLN	712,632	0	3.09
3.10	7.00	OPERATION OF PLANT	SARAH BUSH LINCOLN	28,967	0	3.10
3.11	30.00	ADULTS & PEDIATRICS	SARAH BUSH LINCOLN	78,509	0	3.11
3.12	0.00			0	0	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
3.16	0.00			0	0	3.16
3.17	0.00			0	0	3.17
3.18	0.00			0	0	3.18
4.00	0.00			0	0	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
5.00	0			4,035,824	1,816,874	5.00

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

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

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

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

6.00	B	ALLIANT MGT	100.00	0.00	6.00
7.00	B	BLUEGRASS LEAS	100.00	0.00	7.00
8.00	B	ALLIANT PURCH	100.00	0.00	8.00
9.00	B	HEARTLAND STELM	100.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER			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: 14-1346

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

Worksheet A-8-1

Date/Time Prepared:
8/26/2020 3:56 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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	-1,021,500	0		3.05
3.06	963,147	9		3.06
3.07	0	0		3.07
3.08	1,457,195	0		3.08
3.09	712,632	0		3.09
3.10	28,967	0		3.10
3.11	78,509	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
3.18	0	0		3.18
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	9		4.02
4.03	0	9		4.03
5.00	2,218,950			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1346

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

Worksheet A-8-2

Date/Time Prepared:
8/26/2020 3:56 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	127,824	102,565	25,259	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	28,187	28,187	0	0	0	2.00
3.00	90.01	WOUND CARE	27,061	27,061	0	0	0	3.00
4.00	90.02	PAIN MANAGEMENT	155,000	155,000	0	0	0	4.00
5.00	90.04	DR SKOW	321,827	299,968	21,859	0	0	5.00
6.00	90.05	DR BLASER	619,390	612,104	7,286	0	0	6.00
7.00	90.06	DR. RONHOLM	86,005	86,005	0	0	0	7.00
8.00	90.07	DR. BARKOVIK	99,000	99,000	0	0	0	8.00
9.00	90.10	DR. RAJU	28,281	28,281	0	0	0	9.00
10.00	91.00	EMERGENCY	1,804,503	930,764	873,739	0	0	10.00
200.00			3,297,078	2,368,935	928,143			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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	90.01	WOUND CARE	0	0	0	0	0	3.00
4.00	90.02	PAIN MANAGEMENT	0	0	0	0	0	4.00
5.00	90.04	DR SKOW	0	0	0	0	0	5.00
6.00	90.05	DR BLASER	0	0	0	0	0	6.00
7.00	90.06	DR. RONHOLM	0	0	0	0	0	7.00
8.00	90.07	DR. BARKOVIK	0	0	0	0	0	8.00
9.00	90.10	DR. RAJU	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	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	102,565		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	28,187		2.00
3.00	90.01	WOUND CARE	0	0	0	27,061		3.00
4.00	90.02	PAIN MANAGEMENT	0	0	0	155,000		4.00
5.00	90.04	DR SKOW	0	0	0	299,968		5.00
6.00	90.05	DR BLASER	0	0	0	612,104		6.00
7.00	90.06	DR. RONHOLM	0	0	0	86,005		7.00
8.00	90.07	DR. BARKOVIK	0	0	0	99,000		8.00
9.00	90.10	DR. RAJU	0	0	0	28,281		9.00
10.00	91.00	EMERGENCY	0	0	0	930,764		10.00
200.00			0	0	0	2,368,935		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,156,200	1,156,200			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	374,975	374,975			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,552,498	5,002	904	4,558,404	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,189,487	67,706	113,801	428,505	4,799,499
7.00	00700	OPERATION OF PLANT	378,586	371,359	7,834	97,545	855,324
7.01	00701	OPERATION OF PLANT HOSP ONLY	607,504	0	0	0	607,504
7.02	00702	OPERATION OF PLANT ANNEX ONLY	12,278	0	0	0	12,278
8.00	00800	LAUNDRY & LINEN SERVICE	133,278	19,833	0	36,088	189,199
9.00	00900	HOUSEKEEPING	525,895	5,962	0	165,147	697,004
10.00	01000	DIETARY	535,646	32,611	5,426	97,348	671,031
11.00	01100	CAFETERIA	115,396	0	0	37,237	152,633
13.00	01300	NURSING ADMINISTRATION	155,595	13,140	0	55,729	224,464
14.00	01400	CENTRAL SERVICES & SUPPLY	125,933	7,935	0	22,957	156,825
15.00	01500	PHARMACY	125,396	0	0	80,322	205,718
16.00	01600	MEDICAL RECORDS & LIBRARY	580,629	19,762	0	154,682	755,073
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,266,455	58,062	4,592	408,204	1,737,313
31.00	03100	INTENSIVE CARE UNIT	20,793	6,931	0	7,077	34,801
44.00	04400	SKILLED NURSING FACILITY	1,342,939	232,531	5,445	622,026	2,202,941
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	805,065	42,386	157,609	231,524	1,236,584
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,106,063	30,594	9,828	132,215	1,278,700
55.00	05500	RADIOLOGY-THERAPEUTIC	315,184	0	0	37,849	353,033
60.00	06000	LABORATORY	1,728,806	43,540	48,286	291,174	2,111,806
65.00	06500	RESPIRATORY THERAPY	205,146	7,961	2,255	62,253	277,615
66.00	06600	PHYSICAL THERAPY	563,287	18,379	0	201,225	782,891
67.00	06700	OCCUPATIONAL THERAPY	84,446	1,497	0	31,468	117,411
68.00	06800	SPEECH PATHOLOGY	91,487	0	0	34,066	125,553
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	328,939	0	0	0	328,939
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	253,168	0	0	0	253,168
73.00	07300	DRUGS CHARGED TO PATIENTS	1,351,986	0	0	0	1,351,986
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	974,892	0	1,876	337,874	1,314,642
88.01	08801	RURAL HEALTH CLINIC II	194,982	0	0	49,793	244,775
90.00	09000	CLINIC	598,291	60,511	1,255	0	660,057
90.01	09002	WOUND CARE	156,147	1,929	0	0	158,076
90.02	09003	PAIN MANAGEMENT	27,399	1,929	0	9,168	38,496
90.03	09001	NEUROLOGY	0	0	0	0	0
90.04	09004	DR SKOW	197,039	4,676	0	81,768	283,483
90.05	09005	DR BLASER	82,500	9,062	0	56,911	148,473
90.06	09006	DR. RONHOLM	33,745	1,929	0	11,342	47,016
90.07	09007	DR. BARKOVIK	29,082	1,929	0	9,748	40,759
90.08	04950	NP LANGSTON	9,271	3,505	0	0	12,776
90.09	09008	OP NURSING SERVICE	69,612	4,192	0	24,360	98,164
90.10	09009	DR. RAJU	14,136	0	0	4,838	18,974
91.00	09100	EMERGENCY	2,057,051	24,826	3,974	425,433	2,511,284
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	5,221	0	697	774	6,692
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,482,428	1,099,679	363,782	4,246,650	27,102,960
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	4,993	0	0	4,993
192.00	19200	PHYSICIANS' PRIVATE OFFICES	945,434	51,528	11,193	311,754	1,319,909
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		TOTAL (sum lines 118 through 201)	28,427,862	1,156,200	374,975	4,558,404	28,427,862

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,799,499					5.00
7.00	00700	OPERATION OF PLANT	173,737	1,029,061				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	123,399	0	730,903			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	2,494	0	0	14,772		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	38,431	28,659	22,246	0	278,535	8.00
9.00	00900	HOUSEKEEPING	141,578	8,615	6,687	0	21,246	9.00
10.00	01000	DIETARY	136,303	47,124	36,579	0	2,696	10.00
11.00	01100	CAFETERIA	31,003	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	45,594	18,987	14,738	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,855	11,466	8,900	0	0	14.00
15.00	01500	PHARMACY	41,786	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,373	28,557	22,167	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	352,890	83,902	65,127	0	45,320	30.00
31.00	03100	INTENSIVE CARE UNIT	7,069	10,015	7,774	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	447,470	336,019	260,824	0	137,445	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	251,180	61,250	47,543	0	13,741	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	259,735	44,210	34,317	0	1,788	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	71,709	0	0	0	0	55.00
60.00	06000	LABORATORY	428,958	62,917	48,837	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	56,390	11,504	8,930	0	31	65.00
66.00	06600	PHYSICAL THERAPY	159,024	26,559	20,616	0	11,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,849	2,163	1,679	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	25,503	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,815	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	51,424	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	274,621	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	267,035	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	49,720	0	0	0	0	88.01
90.00	09000	CLINIC	134,073	87,440	0	14,772	0	90.00
90.01	09002	WOUND CARE	32,109	2,787	2,163	0	0	90.01
90.02	09003	PAIN MANAGEMENT	7,819	2,787	2,163	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	57,582	6,757	5,245	0	0	90.04
90.05	09005	DR BLASER	30,158	13,095	10,165	0	0	90.05
90.06	09006	DR. RONHOLM	9,550	2,787	2,163	0	0	90.06
90.07	09007	DR. BARKOVIK	8,279	2,787	2,163	0	0	90.07
90.08	04950	NP LANGSTON	2,595	5,065	3,931	0	0	90.08
90.09	09008	OP NURSING SERVICE	19,939	6,058	4,702	0	0	90.09
90.10	09009	DR. RAJU	3,854	0	0	0	0	90.10
91.00	09100	EMERGENCY	510,118	35,875	27,846	0	21,368	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,359	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,530,380	947,385	667,505	14,772	255,182	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,014	7,216	5,601	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	268,105	74,460	57,797	0	197	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	37	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	23,119	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,799,499	1,029,061	730,903	14,772	278,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	875,130					9.00
10.00	01000	DIETARY	41,581	935,314				10.00
11.00	01100	CAFETERIA	0	0	183,636			11.00
13.00	01300	NURSING ADMINISTRATION	16,754	0	2,645	323,182		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,117	0	3,307	0	222,470	14.00
15.00	01500	PHARMACY	0	0	3,486	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,198	0	10,016	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	74,034	234,240	28,009	145,813	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,837	0	482	2,510	0	31.00
44.00	04400	SKILLED NURSING FACILITY	296,494	701,074	53,538	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,046	0	11,766	61,251	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	39,010	0	9,313	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	2,673	0	0	55.00
60.00	06000	LABORATORY	55,517	0	19,756	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	10,151	0	4,271	0	0	65.00
66.00	06600	PHYSICAL THERAPY	23,435	0	9,768	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,909	0	1,405	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,378	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	125,708	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	96,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	77,155	0	0	0	0	90.00
90.01	09002	WOUND CARE	2,459	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	2,459	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	5,963	0	0	0	0	90.04
90.05	09005	DR BLASER	11,555	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	2,459	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	2,459	0	0	0	0	90.07
90.08	04950	NP LANGSTON	4,469	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	5,345	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	0	90.10
91.00	09100	EMERGENCY	31,655	0	21,093	109,807	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	730	3,801	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	803,061	935,314	183,636	323,182	222,470	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,367	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	65,702	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	875,130	935,314	183,636	323,182	222,470	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
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	250,990					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	994,384				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	61,228	2,827,876	0	2,827,876	30.00
31.00	03100	INTENSIVE CARE UNIT	0	849	72,337	0	72,337	31.00
44.00	04400	SKILLED NURSING FACILITY	0	40,919	4,476,724	0	4,476,724	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33,298	1,770,659	0	1,770,659	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	202,678	1,869,751	0	1,869,751	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	8,117	435,532	0	435,532	55.00
60.00	06000	LABORATORY	0	221,587	2,949,378	0	2,949,378	60.00
65.00	06500	RESPIRATORY THERAPY	0	29,440	398,332	0	398,332	65.00
66.00	06600	PHYSICAL THERAPY	0	33,508	1,067,348	0	1,067,348	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,716	154,132	0	154,132	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,008	156,442	0	156,442	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,405	551,867	0	551,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	16,351	417,705	0	417,705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,990	106,614	1,984,211	0	1,984,211	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	17,635	1,599,312	0	1,599,312	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,501	296,996	0	296,996	88.01
90.00	09000	CLINIC	0	32,215	1,005,712	0	1,005,712	90.00
90.01	09002	WOUND CARE	0	7,302	204,896	0	204,896	90.01
90.02	09003	PAIN MANAGEMENT	0	615	54,339	0	54,339	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	1,460	360,490	0	360,490	90.04
90.05	09005	DR BLASER	0	2,465	215,911	0	215,911	90.05
90.06	09006	DR. RONHOLM	0	890	64,865	0	64,865	90.06
90.07	09007	DR. BARKOVIK	0	1,086	57,533	0	57,533	90.07
90.08	04950	NP LANGSTON	0	1,824	30,660	0	30,660	90.08
90.09	09008	OP NURSING SERVICE	0	8,223	142,431	0	142,431	90.09
90.10	09009	DR. RAJU	0	255	23,083	0	23,083	90.10
91.00	09100	EMERGENCY	0	123,193	3,392,239	0	3,392,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2	12,584	0	12,584	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	250,990	994,384	26,593,345	0	26,593,345	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	25,191	0	25,191	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,786,170	0	1,786,170	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	37	0	37	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	23,119	0	23,119	192.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	250,990	994,384	28,427,862	0	28,427,862	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,002	904	5,906	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	67,706	113,801	181,507	5.00
7.00	00700	OPERATION OF PLANT	0	371,359	7,834	379,193	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,833	0	19,833	8.00
9.00	00900	HOUSEKEEPING	0	5,962	0	5,962	9.00
10.00	01000	DIETARY	0	32,611	5,426	38,037	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,140	0	13,140	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,935	0	7,935	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,762	0	19,762	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	58,062	4,592	62,654	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,931	0	6,931	31.00
44.00	04400	SKILLED NURSING FACILITY	0	232,531	5,445	237,976	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	42,386	157,609	199,995	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,594	9,828	40,422	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
60.00	06000	LABORATORY	0	43,540	48,286	91,826	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,961	2,255	10,216	65.00
66.00	06600	PHYSICAL THERAPY	0	18,379	0	18,379	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,497	0	1,497	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	1,876	1,876	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	0	60,511	1,255	61,766	90.00
90.01	09001	WOUND CARE	0	1,929	0	1,929	90.01
90.02	09002	PAIN MANAGEMENT	0	1,929	0	1,929	90.02
90.03	09003	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	0	4,676	0	4,676	90.04
90.05	09005	DR BLASER	0	9,062	0	9,062	90.05
90.06	09006	DR. RONHOLM	0	1,929	0	1,929	90.06
90.07	09007	DR. BARKOVIK	0	1,929	0	1,929	90.07
90.08	04950	NP LANGSTON	0	3,505	0	3,505	90.08
90.09	09008	OP NURSING SERVICE	0	4,192	0	4,192	90.09
90.10	09009	DR. RAJU	0	0	0	0	90.10
91.00	09100	EMERGENCY	0	24,826	3,974	28,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	697	697	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,099,679	363,782	1,463,461	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,993	0	4,993	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	51,528	11,193	62,721	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	192.03
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,156,200	374,975	1,531,175	202.00

8/26/2020 3:56 pm

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT HOSP ONLY	OPERATION OF PLANT ANNEX ONLY	LAUNDRY & LINEN SERVICE	
			5.00	7.00	7.01	7.02	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	182,062					5.00
7.00	00700	OPERATION OF PLANT	6,590	385,909				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	4,681	0	4,681			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	95	0	0	95		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	1,458	10,747	142	0	32,227	8.00
9.00	00900	HOUSEKEEPING	5,370	3,231	43	0	2,458	9.00
10.00	01000	DIETARY	5,170	17,672	234	0	312	10.00
11.00	01100	CAFETERIA	1,176	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,729	7,120	94	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,208	4,300	57	0	0	14.00
15.00	01500	PHARMACY	1,585	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,818	10,709	142	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,386	31,464	417	0	5,244	30.00
31.00	03100	INTENSIVE CARE UNIT	268	3,756	50	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	16,974	126,013	1,671	0	15,902	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,528	22,969	304	0	1,590	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,852	16,579	220	0	207	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,720	0	0	0	0	55.00
60.00	06000	LABORATORY	16,271	23,595	313	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,139	4,314	57	0	4	65.00
66.00	06600	PHYSICAL THERAPY	6,032	9,960	132	0	1,336	66.00
67.00	06700	OCCUPATIONAL THERAPY	905	811	11	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	967	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,534	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,951	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,417	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,129	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,886	0	0	0	0	88.01
90.00	09000	CLINIC	5,086	32,791	0	95	0	90.00
90.01	09002	WOUND CARE	1,218	1,045	14	0	0	90.01
90.02	09003	PAIN MANAGEMENT	297	1,045	14	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	2,184	2,534	34	0	0	90.04
90.05	09005	DR BLASER	1,144	4,911	65	0	0	90.05
90.06	09006	DR. RONHOLM	362	1,045	14	0	0	90.06
90.07	09007	DR. BARKOVIK	314	1,045	14	0	0	90.07
90.08	04950	NP LANGSTON	98	1,899	25	0	0	90.08
90.09	09008	OP NURSING SERVICE	756	2,272	30	0	0	90.09
90.10	09009	DR. RAJU	146	0	0	0	0	90.10
91.00	09100	EMERGENCY	19,358	13,453	178	0	2,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	52	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	171,854	355,280	4,275	95	29,525	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38	2,706	36	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,170	27,923	370	0	23	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	4	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	2,675	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	182,062	385,909	4,681	95	32,227	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	17,278					9.00
10.00	01000	DIETARY	821	62,372				10.00
11.00	01100	CAFETERIA	0	0	1,224			11.00
13.00	01300	NURSING ADMINISTRATION	331	0	18	22,504		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	200	0	22	0	13,752	14.00
15.00	01500	PHARMACY	0	0	23	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	497	0	67	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,462	15,620	187	10,153	0	30.00
31.00	03100	INTENSIVE CARE UNIT	174	0	3	175	0	31.00
44.00	04400	SKILLED NURSING FACILITY	5,852	46,752	357	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,067	0	78	4,265	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	770	0	62	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	18	0	0	55.00
60.00	06000	LABORATORY	1,096	0	132	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	200	0	28	0	0	65.00
66.00	06600	PHYSICAL THERAPY	463	0	65	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	38	0	9	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	9	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	7,771	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	5,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	1,523	0	0	0	0	90.00
90.01	09002	WOUND CARE	49	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	49	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	118	0	0	0	0	90.04
90.05	09005	DR BLASER	228	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	49	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	49	0	0	0	0	90.07
90.08	04950	NP LANGSTON	88	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	106	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	0	90.10
91.00	09100	EMERGENCY	625	0	141	7,646	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	5	265	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,855	62,372	1,224	22,504	13,752	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	126	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,297	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,278	62,372	1,224	22,504	13,752	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part II
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY						7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY						7.02
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	1,712					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,195				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,288	143,403	0	143,403	30.00
31.00	03100	INTENSIVE CARE UNIT	0	32	11,398	0	11,398	31.00
44.00	04400	SKILLED NURSING FACILITY	0	1,529	453,834	0	453,834	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,244	241,340	0	241,340	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,574	75,857	0	75,857	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	303	3,090	0	3,090	55.00
60.00	06000	LABORATORY	0	8,316	141,926	0	141,926	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,100	18,139	0	18,139	65.00
66.00	06600	PHYSICAL THERAPY	0	1,252	37,880	0	37,880	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	214	3,526	0	3,526	67.00
68.00	06800	SPEECH PATHOLOGY	0	150	1,170	0	1,170	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,136	11,441	0	11,441	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	611	8,543	0	8,543	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,712	3,984	16,113	0	16,113	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	659	13,101	0	13,101	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	93	2,043	0	2,043	88.01
90.00	09000	CLINIC	0	1,204	102,465	0	102,465	90.00
90.01	09002	WOUND CARE	0	273	4,528	0	4,528	90.01
90.02	09003	PAIN MANAGEMENT	0	23	3,369	0	3,369	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	55	9,707	0	9,707	90.04
90.05	09005	DR BLASER	0	92	15,576	0	15,576	90.05
90.06	09006	DR. RONHOLM	0	33	3,447	0	3,447	90.06
90.07	09007	DR. BARKOVIK	0	41	3,405	0	3,405	90.07
90.08	04950	NP LANGSTON	0	68	5,683	0	5,683	90.08
90.09	09008	OP NURSING SERVICE	0	307	7,695	0	7,695	90.09
90.10	09009	DR. RAJU	0	10	162	0	162	90.10
91.00	09100	EMERGENCY	0	4,604	77,828	0	77,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	1,020	0	1,020	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,712	37,195	1,417,689	0	1,417,689	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	7,899	0	7,899	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	102,908	0	102,908	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	4	0	4	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	2,675	0	2,675	192.03
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,712	37,195	1,531,175	0	1,531,175	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	131,287				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		442,521			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	568	1,067	11,414,829		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,688	134,300	1,073,030	-4,799,499	5.00
7.00	00700	OPERATION OF PLANT	42,168	9,245	244,266	0	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	0	0	0	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	0	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,252	0	90,369	0	8.00
9.00	00900	HOUSEKEEPING	677	0	413,549	0	9.00
10.00	01000	DIETARY	3,703	6,403	243,772	0	10.00
11.00	01100	CAFETERIA	0	0	93,245	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,492	0	139,552	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	901	0	57,488	0	14.00
15.00	01500	PHARMACY	0	0	201,137	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,244	0	387,344	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,593	5,419	1,022,195	0	30.00
31.00	03100	INTENSIVE CARE UNIT	787	0	17,721	0	31.00
44.00	04400	SKILLED NURSING FACILITY	26,404	6,426	1,557,638	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,813	186,001	579,766	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,474	11,598	331,084	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	94,779	0	55.00
60.00	06000	LABORATORY	4,944	56,984	729,135	0	60.00
65.00	06500	RESPIRATORY THERAPY	904	2,661	155,889	0	65.00
66.00	06600	PHYSICAL THERAPY	2,087	0	503,892	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	0	78,801	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	85,306	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,214	846,080	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	124,687	0	88.01
90.00	09000	CLINIC	6,871	1,481	0	0	90.00
90.01	09002	WOUND CARE	219	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	219	0	22,959	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	531	0	204,757	0	90.04
90.05	09005	DR BLASER	1,029	0	142,512	0	90.05
90.06	09006	DR. RONHOLM	219	0	28,403	0	90.06
90.07	09007	DR. BARKOVIK	219	0	24,409	0	90.07
90.08	04950	NP LANGSTON	398	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	476	0	61,000	0	90.09
90.10	09009	DR. RAJU	0	0	12,116	0	90.10
91.00	09100	EMERGENCY	2,819	4,690	1,065,338	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	823	1,939	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	124,869	429,312	10,634,158	-4,799,499	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	567	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,851	13,209	780,671	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	192.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,156,200	374,975	4,558,404	4,799,499	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.806660	0.847361	0.399341	0.203124	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,906	182,062	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000517	0.007705	205.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
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: 14-1346

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQ FT)	OPERATION OF PLANT HOSP ONLY (SQ FT)	OPERATION OF PLANT ANNEX ONLY (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		7.00	7.01	7.02	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	80,863				7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	0	73,992			7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	0	0	6,871		7.02
8.00	00800	LAUNDRY & LINEN SERVICE	2,252	2,252	0	406,523	8.00
9.00	00900	HOUSEKEEPING	677	677	0	31,008	9.00
10.00	01000	DIETARY	3,703	3,703	0	3,935	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,492	1,492	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	901	901	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,244	2,244	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,593	6,593	0	66,145	30.00
31.00	03100	INTENSIVE CARE UNIT	787	787	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	26,404	26,404	0	200,602	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,813	4,813	0	20,055	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,474	3,474	0	2,610	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
60.00	06000	LABORATORY	4,944	4,944	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	904	904	0	45	65.00
66.00	06600	PHYSICAL THERAPY	2,087	2,087	0	16,853	66.00
67.00	06700	OCCUPATIONAL THERAPY	170	170	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	6,871	0	6,871	0	90.00
90.01	09002	WOUND CARE	219	219	0	0	90.01
90.02	09003	PAIN MANAGEMENT	219	219	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	531	531	0	0	90.04
90.05	09005	DR BLASER	1,029	1,029	0	0	90.05
90.06	09006	DR. RONHOLM	219	219	0	0	90.06
90.07	09007	DR. BARKOVIK	219	219	0	0	90.07
90.08	04950	NP LANGSTON	398	398	0	0	90.08
90.09	09008	OP NURSING SERVICE	476	476	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	90.10
91.00	09100	EMERGENCY	2,819	2,819	0	31,186	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,445	67,574	6,871	372,439	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	567	567	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,851	5,851	0	287	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	54	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	33,743	192.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,029,061	730,903	14,772	278,535	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.725981	9.878135	2.149905	0.685164	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	385,909	4,681	95	32,227	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.772380	0.063264	0.013826	0.079275	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description			OPERATION OF PLANT (SQ FT)	OPERATION OF PLANT HOSP ONLY (SQ FT)	OPERATION OF PLANT ANNEX ONLY (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	7.00	7.01	7.02	8.00	9.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATION (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY					7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY					7.02
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY	67,625				10.00
11.00	01100	CAFETERIA	0	13,329			11.00
13.00	01300	NURSING ADMINISTRATION	0	192	4,506		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	240	0	582,072	14.00
15.00	01500	PHARMACY	0	253	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	727	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,936	2,033	2,033	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	35	35	0	31.00
44.00	04400	SKILLED NURSING FACILITY	50,689	3,886	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	854	854	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	676	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	194	0	0	55.00
60.00	06000	LABORATORY	0	1,434	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	310	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	709	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	102	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	100	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	328,904	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	253,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	90.10
91.00	09100	EMERGENCY	0	1,531	1,531	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	53	53	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,625	13,329	4,506	582,072	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	FAYETTE COUNTY ANNEX	0	0	0	0	192.01
192.02	19202	PUBLIC RELATIONS	0	0	0	0	192.02
192.03	19203	PERSONAL LAUNDRY	0	0	0	0	192.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	935,314	183,636	323,182	222,470	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.830891	13.777178	71.722592	0.382204	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	62,372	1,224	22,504	13,752	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.922322	0.091830	4.994230	0.023626	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (NUMBER OF FTE'S)	NURSING ADMINISTRATION (NUMBER OF FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUISITIONS)	PHARMACY (COSTED REQUISITIONS)	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	10.00	11.00	13.00	14.00	15.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
7.01	00701	OPERATION OF PLANT HOSP ONLY	7.01
7.02	00702	OPERATION OF PLANT ANNEX ONLY	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		70,650,397	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		2,907,227	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		2,365,787	
		0	
		14,399,870	
		576,696	
		15,744,631	
		2,091,641	
		2,380,681	
		406,138	
		284,768	
		2,160,202	
		1,161,717	
		7,574,689	
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II	88.01
90.00	09000	CLINIC	90.00
90.01	09002	WOUND CARE	90.01
90.02	09003	PAIN MANAGEMENT	90.02
90.03	09001	NEUROLOGY	90.03
90.04	09004	DR SKOW	90.04
90.05	09005	DR BLASER	90.05
90.06	09006	DR. RONHOLM	90.06
90.07	09007	DR. BARKOVIK	90.07
90.08	04950	NP LANGSTON	90.08
90.09	09008	OP NURSING SERVICE	90.09
90.10	09009	DR. RAJU	90.10
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
		1,252,944	
		177,721	
		2,288,832	
		518,779	
		43,715	
		0	
		103,757	
		175,143	
		63,232	
		77,128	
		129,624	
		584,230	
		18,083	
		8,752,638	
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
		118	
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		70,650,397	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	FAYETTE COUNTY ANNEX	192.01
192.02	19202	PUBLIC RELATIONS	192.02
192.03	19203	PERSONAL LAUNDRY	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		994,384	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.014075	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		37,195	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000526	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1346

Period:
From 01/01/2019
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	16.00	207.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
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			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	3,385,523		3,385,523			30.00
31.00	03100	INTENSIVE CARE UNIT	60,290		60,290			31.00
44.00	04400	SKILLED NURSING FACILITY	2,907,227		2,907,227			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	191,942	2,173,845	2,365,787	0.748444	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	789,546	13,610,324	14,399,870	0.129845	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	59,010	517,686	576,696	0.755219	0.000000	55.00
60.00	06000	LABORATORY	1,696,364	14,048,267	15,744,631	0.187326	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	692,190	1,399,451	2,091,641	0.190440	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	602,980	1,777,701	2,380,681	0.448337	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,119	227,019	406,138	0.379506	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	119,533	165,235	284,768	0.549367	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,224,471	935,731	2,160,202	0.255470	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	951,344	210,373	1,161,717	0.359558	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,393,977	5,180,712	7,574,689	0.261953	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	77,845	1,175,099	1,252,944			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	177,721	177,721			88.01
90.00	09000	CLINIC	0	2,288,832	2,288,832	0.439400	0.000000	90.00
90.01	09002	WOUND CARE	83,678	435,101	518,779	0.394958	0.000000	90.01
90.02	09003	PAIN MANAGEMENT	0	43,715	43,715	1.243029	0.000000	90.02
90.03	09001	NEUROLOGY	0	0	0	0.000000	0.000000	90.03
90.04	09004	DR SKOW	191	103,566	103,757	3.474368	0.000000	90.04
90.05	09005	DR BLASER	0	175,143	175,143	1.232770	0.000000	90.05
90.06	09006	DR. RONHOLM	0	63,232	63,232	1.025826	0.000000	90.06
90.07	09007	DR. BARKOVIK	0	77,128	77,128	0.745942	0.000000	90.07
90.08	04950	NP LANGSTON	0	129,624	129,624	0.236530	0.000000	90.08
90.09	09008	OP NURSING SERVICE	0	584,230	584,230	0.243793	0.000000	90.09
90.10	09009	DR. RAJU	0	18,083	18,083	1.276503	0.000000	90.10
91.00	09100	EMERGENCY	3,585	8,749,053	8,752,638	0.387568	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,909	961,684	964,593	0.298410	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	118	118	106.644068	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,421,724	55,228,673	70,650,397			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,421,724	55,228,673	70,650,397			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/26/2020 3:56 pm
				Title XVIII	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.748444			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129845			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.755219			55.00
60.00	06000	LABORATORY	0.187326			60.00
65.00	06500	RESPIRATORY THERAPY	0.190440			65.00
66.00	06600	PHYSICAL THERAPY	0.448337			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379506			67.00
68.00	06800	SPEECH PATHOLOGY	0.549367			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255470			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.359558			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261953			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	0.439400			90.00
90.01	09002	WOUND CARE	0.394958			90.01
90.02	09003	PAIN MANAGEMENT	1.243029			90.02
90.03	09001	NEUROLOGY	0.000000			90.03
90.04	09004	DR SKOW	3.474368			90.04
90.05	09005	DR BLASER	1.232770			90.05
90.06	09006	DR. RONHOLM	1.025826			90.06
90.07	09007	DR. BARKOVIK	0.745942			90.07
90.08	04950	NP LANGSTON	0.236530			90.08
90.09	09008	OP NURSING SERVICE	0.243793			90.09
90.10	09009	DR. RAJU	1.276503			90.10
91.00	09100	EMERGENCY	0.387568			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.298410			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	106.644068			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet C
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			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,827,876		2,827,876	0
31.00	03100	INTENSIVE CARE UNIT	72,337		72,337	0
44.00	04400	SKILLED NURSING FACILITY	4,476,724		4,476,724	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,770,659		1,770,659	0
53.00	05300	ANESTHESIOLOGY	0		0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,869,751		1,869,751	0
55.00	05500	RADIOLOGY-THERAPEUTIC	435,532		435,532	0
60.00	06000	LABORATORY	2,949,378		2,949,378	0
65.00	06500	RESPIRATORY THERAPY	398,332	0	398,332	0
66.00	06600	PHYSICAL THERAPY	1,067,348	0	1,067,348	0
67.00	06700	OCCUPATIONAL THERAPY	154,132	0	154,132	0
68.00	06800	SPEECH PATHOLOGY	156,442	0	156,442	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	551,867		551,867	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	417,705		417,705	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,984,211		1,984,211	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,599,312		1,599,312	0
88.01	08801	RURAL HEALTH CLINIC II	296,996		296,996	0
90.00	09000	CLINIC	1,005,712		1,005,712	0
90.01	09002	WOUND CARE	204,896		204,896	0
90.02	09003	PAIN MANAGEMENT	54,339		54,339	0
90.03	09001	NEUROLOGY	0		0	0
90.04	09004	DR SKOW	360,490		360,490	0
90.05	09005	DR BLASER	215,911		215,911	0
90.06	09006	DR. RONHOLM	64,865		64,865	0
90.07	09007	DR. BARKOVIK	57,533		57,533	0
90.08	04950	NP LANGSTON	30,660		30,660	0
90.09	09008	OP NURSING SERVICE	142,431		142,431	0
90.10	09009	DR. RAJU	23,083		23,083	0
91.00	09100	EMERGENCY	3,392,239		3,392,239	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	287,844		287,844	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	12,584		12,584	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				
200.00		Subtotal (see instructions)	26,881,189	0	26,881,189	0
201.00		Less Observation Beds	287,844		287,844	0
202.00		Total (see instructions)	26,593,345	0	26,593,345	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1346

Period:
From 01/01/2019
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,385,523		3,385,523		30.00
31.00	03100	INTENSIVE CARE UNIT	60,290		60,290		31.00
44.00	04400	SKILLED NURSING FACILITY	2,907,227		2,907,227		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	187,116	2,166,123	2,353,239	0.752435	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	789,546	13,610,324	14,399,870	0.129845	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	59,010	517,686	576,696	0.755219	55.00
60.00	06000	LABORATORY	1,696,364	14,048,267	15,744,631	0.187326	60.00
65.00	06500	RESPIRATORY THERAPY	692,190	1,399,451	2,091,641	0.190440	65.00
66.00	06600	PHYSICAL THERAPY	602,980	1,777,701	2,380,681	0.448337	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,119	227,019	406,138	0.379506	67.00
68.00	06800	SPEECH PATHOLOGY	119,533	165,235	284,768	0.549367	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,224,471	935,731	2,160,202	0.255470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	951,344	210,373	1,161,717	0.359558	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,393,977	5,180,712	7,574,689	0.261953	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	77,845	1,175,099	1,252,944	1.276443	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	177,721	177,721	1.671136	88.01
90.00	09000	CLINIC	0	2,288,832	2,288,832	0.439400	90.00
90.01	09002	WOUND CARE	83,678	435,101	518,779	0.394958	90.01
90.02	09003	PAIN MANAGEMENT	0	43,715	43,715	1.243029	90.02
90.03	09001	NEUROLOGY	0	0	0	0.000000	90.03
90.04	09004	DR SKOW	191	103,566	103,757	3.474368	90.04
90.05	09005	DR BLASER	0	175,143	175,143	1.232770	90.05
90.06	09006	DR. RONHOLM	0	63,232	63,232	1.025826	90.06
90.07	09007	DR. BARKOVIK	0	77,128	77,128	0.745942	90.07
90.08	04950	NP LANGSTON	0	129,624	129,624	0.236530	90.08
90.09	09008	OP NURSING SERVICE	0	584,230	584,230	0.243793	90.09
90.10	09009	DR. RAJU	0	18,083	18,083	1.276503	90.10
91.00	09100	EMERGENCY	3,585	8,749,053	8,752,638	0.387568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,735	970,406	977,141	0.294578	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	118	118	106.644068	95.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,420,724	55,229,673	70,650,397		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,420,724	55,229,673	70,650,397		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000			88.01
90.00	09000	CLINIC	0.000000			90.00
90.01	09002	WOUND CARE	0.000000			90.01
90.02	09003	PAIN MANAGEMENT	0.000000			90.02
90.03	09001	NEUROLOGY	0.000000			90.03
90.04	09004	DR SKOW	0.000000			90.04
90.05	09005	DR BLASER	0.000000			90.05
90.06	09006	DR. RONHOLM	0.000000			90.06
90.07	09007	DR. BARKOVIK	0.000000			90.07
90.08	04950	NP LANGSTON	0.000000			90.08
90.09	09008	OP NURSING SERVICE	0.000000			90.09
90.10	09009	DR. RAJU	0.000000			90.10
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part II
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	241,340	2,365,787	0.102013	111,568	11,381	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	75,857	14,399,870	0.005268	407,287	2,146	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	3,090	576,696	0.005358	34,188	183	55.00
60.00	06000 LABORATORY	141,926	15,744,631	0.009014	808,008	7,283	60.00
65.00	06500 RESPIRATORY THERAPY	18,139	2,091,641	0.008672	310,192	2,690	65.00
66.00	06600 PHYSICAL THERAPY	37,880	2,380,681	0.015911	103,361	1,645	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,526	406,138	0.008682	16,154	140	67.00
68.00	06800 SPEECH PATHOLOGY	1,170	284,768	0.004109	24,113	99	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,441	2,160,202	0.005296	621,134	3,290	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8,543	1,161,717	0.007354	612,620	4,505	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,113	7,574,689	0.002127	896,661	1,907	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	13,101	1,252,944	0.010456	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	2,043	177,721	0.011496	0	0	88.01
90.00	09000 CLINIC	102,465	2,288,832	0.044767	0	0	90.00
90.01	09002 WOUND CARE	4,528	518,779	0.008728	3,861	34	90.01
90.02	09003 PAIN MANAGEMENT	3,369	43,715	0.077067	0	0	90.02
90.03	09001 NEUROLOGY	0	0	0.000000	0	0	90.03
90.04	09004 DR SKOW	9,707	103,757	0.093555	0	0	90.04
90.05	09005 DR BLASER	15,576	175,143	0.088933	0	0	90.05
90.06	09006 DR. RONHOLM	3,447	63,232	0.054514	0	0	90.06
90.07	09007 DR. BARKOVIK	3,405	77,128	0.044147	0	0	90.07
90.08	04950 NP LANGSTON	5,683	129,624	0.043842	0	0	90.08
90.09	09008 OP NURSING SERVICE	7,695	584,230	0.013171	0	0	90.09
90.10	09009 DR. RAJU	162	18,083	0.008959	0	0	90.10
91.00	09100 EMERGENCY	77,828	8,752,638	0.008892	2,705	24	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	14,597	964,593	0.015133	2,046	31	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	822,631	64,297,239		3,953,898	35,358	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 3:56 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	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	0	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	0	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	0	90.10
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description		Title XVIII		Hospital		Cost	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	2,365,787	0.000000 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,399,870	0.000000 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	576,696	0.000000 55.00
60.00	06000	LABORATORY	0	0	0	15,744,631	0.000000 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,091,641	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,380,681	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	406,138	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	284,768	0.000000 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,160,202	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,161,717	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,574,689	0.000000 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,252,944	0.000000 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	177,721	0.000000 88.01
90.00	09000	CLINIC	0	0	0	2,288,832	0.000000 90.00
90.01	09002	WOUND CARE	0	0	0	518,779	0.000000 90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	43,715	0.000000 90.02
90.03	09001	NEUROLOGY	0	0	0	0	0.000000 90.03
90.04	09004	DR SKOW	0	0	0	103,757	0.000000 90.04
90.05	09005	DR BLASER	0	0	0	175,143	0.000000 90.05
90.06	09006	DR. RONHOLM	0	0	0	63,232	0.000000 90.06
90.07	09007	DR. BARKOVIK	0	0	0	77,128	0.000000 90.07
90.08	04950	NP LANGSTON	0	0	0	129,624	0.000000 90.08
90.09	09008	OP NURSING SERVICE	0	0	0	584,230	0.000000 90.09
90.10	09009	DR. RAJU	0	0	0	18,083	0.000000 90.10
91.00	09100	EMERGENCY	0	0	0	8,752,638	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	964,593	0.000000 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	0	0	64,297,239	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
8/26/2020 3:56 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	111,568	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	407,287	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	34,188	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	808,008	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	310,192	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	103,361	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	16,154	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	24,113	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	621,134	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	612,620	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	896,661	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.000000	3,861	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	0.000000	0	0	0	0	90.04
90.05	09005	DR BLASER	0.000000	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0.000000	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	0.000000	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0.000000	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	0.000000	0	0	0	0	90.09
90.10	09009	DR. RAJU	0.000000	0	0	0	0	90.10
91.00	09100	EMERGENCY	0.000000	2,705	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	2,046	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,953,898	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/26/2020 3:56 pm

			Title XVIII		Hospital		8/26/2020 3:36 pm	
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	0.748444	0	964,834	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129845	0	5,836,034	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.755219	0	343,863	0	0	55.00
60.00	06000	LABORATORY	0.187326	0	6,399,488	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.190440	0	630,059	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.448337	0	798,068	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379506	0	108,089	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.549367	0	93,769	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255470	0	259,467	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.359558	0	156,454	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261953	0	2,869,576	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.439400	0	2,194,136	0	0	90.00
90.01	09002	WOUND CARE	0.394958	0	366,608	0	0	90.01
90.02	09003	PAIN MANAGEMENT	1.243029	0	13,518	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	90.03
90.04	09004	DR SKOW	3.474368	0	31,981	0	0	90.04
90.05	09005	DR BLASER	1.232770	0	54,805	0	0	90.05
90.06	09006	DR. RONHOLM	1.025826	0	19,554	0	0	90.06
90.07	09007	DR. BARKOVIK	0.745942	0	23,851	0	0	90.07
90.08	04950	NP LANGSTON	0.236530	0	40,085	0	0	90.08
90.09	09008	OP NURSING SERVICE	0.243793	0	263,007	0	0	90.09
90.10	09009	DR. RAJU	1.276503	0	5,592	0	0	90.10
91.00	09100	EMERGENCY	0.387568	0	2,682,830	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.298410	0	531,710	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	106.644068		0			95.00
200.00		Subtotal (see instructions)		0	24,687,378	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	24,687,378	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1346		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 8/26/2020 3:56 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	722,124	0					50.00
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	757,780	0					54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	259,692	0					55.00
60.00	06000	LABORATORY	1,198,790	0					60.00
65.00	06500	RESPIRATORY THERAPY	119,988	0					65.00
66.00	06600	PHYSICAL THERAPY	357,803	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	41,020	0					67.00
68.00	06800	SPEECH PATHOLOGY	51,514	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,286	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	56,254	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	751,694	0					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0					88.01
90.00	09000	CLINIC	964,103	0					90.00
90.01	09002	WOUND CARE	144,795	0					90.01
90.02	09003	PAIN MANAGEMENT	16,803	0					90.02
90.03	09001	NEUROLOGY	0	0					90.03
90.04	09004	DR SKOW	111,114	0					90.04
90.05	09005	DR BLASER	67,562	0					90.05
90.06	09006	DR. RONHOLM	20,059	0					90.06
90.07	09007	DR. BARKOVIK	17,791	0					90.07
90.08	04950	NP LANGSTON	9,481	0					90.08
90.09	09008	OP NURSING SERVICE	64,119	0					90.09
90.10	09009	DR. RAJU	7,138	0					90.10
91.00	09100	EMERGENCY	1,039,779	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	158,668	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	7,004,357	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	7,004,357	0					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346

Period:

Worksheet D

Component CCN: 14-Z346

From 01/01/2019
To 12/31/2019Part V
Date/Time Prepared:
8/26/2020 3:56 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	0.748444	0	0	0	0	50.00	
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.129845	0	0	0	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.755219	0	0	0	0	55.00	
60.00	06000 LABORATORY	0.187326	0	0	0	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0.190440	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.448337	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.379506	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.549367	0	0	0	0	68.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255470	0	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.359558	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.261953	0	0	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00	
88.01	08801 RURAL HEALTH CLINIC II	0.000000				0	88.01	
90.00	09000 CLINIC	0.439400	0	0	0	0	90.00	
90.01	09002 WOUND CARE	0.394958	0	0	0	0	90.01	
90.02	09003 PAIN MANAGEMENT	1.243029	0	0	0	0	90.02	
90.03	09001 NEUROLOGY	0.000000	0	0	0	0	90.03	
90.04	09004 DR SKOW	3.474368	0	0	0	0	90.04	
90.05	09005 DR BLASER	1.232770	0	0	0	0	90.05	
90.06	09006 DR. RONHOLM	1.025826	0	0	0	0	90.06	
90.07	09007 DR. BARKOVIK	0.745942	0	0	0	0	90.07	
90.08	04950 NP LANGSTON	0.236530	0	0	0	0	90.08	
90.09	09008 OP NURSING SERVICE	0.243793	0	0	0	0	90.09	
90.10	09009 DR. RAJU	1.276503	0	0	0	0	90.10	
91.00	09100 EMERGENCY	0.387568	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.298410	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	106.644068		0			95.00	
200.00	Subtotal (see instructions)		0	0	0	0	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00	Net Charges (line 200 - line 201)		0	0	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346

Period:

Worksheet D

Component CCN: 14-Z346

From 01/01/2019

Part V

To 12/31/2019

Date/Time Prepared:

8/26/2020 3:56 pm

			Title XVIII		Swing Beds - SNF	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09002	WOUND CARE	0	0		90.01
90.02	09003	PAIN MANAGEMENT	0	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR SKOW	0	0		90.04
90.05	09005	DR BLASER	0	0		90.05
90.06	09006	DR. RONHOLM	0	0		90.06
90.07	09007	DR. BARKOVIK	0	0		90.07
90.08	04950	NP LANGSTON	0	0		90.08
90.09	09008	OP NURSING SERVICE	0	0		90.09
90.10	09009	DR. RAJU	0	0		90.10
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1346 Component CCN: 14-5499		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 3:56 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0	0	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0	0	0	0	0	0	90.03
90.04	09004	DR SKOW	0	0	0	0	0	0	90.04
90.05	09005	DR BLASER	0	0	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0	0	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	0	0	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0	0	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	0	0	0	0	0	0	90.09
90.10	09009	DR. RAJU	0	0	0	0	0	0	90.10
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1346 Component CCN: 14-5499		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 3:56 pm	
				Title XVIII		Skilled Nursing Facility		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	2,365,787	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	14,399,870	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	576,696	0.000000	55.00
60.00	06000	LABORATORY		0	0	0	15,744,631	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	2,091,641	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	2,380,681	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	406,138	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	284,768	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	2,160,202	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT		0	0	0	1,161,717	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	7,574,689	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	1,252,944	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	177,721	0.000000	88.01
90.00	09000	CLINIC		0	0	0	2,288,832	0.000000	90.00
90.01	09002	WOUND CARE		0	0	0	518,779	0.000000	90.01
90.02	09003	PAIN MANAGEMENT		0	0	0	43,715	0.000000	90.02
90.03	09001	NEUROLOGY		0	0	0	0	0.000000	90.03
90.04	09004	DR SKOW		0	0	0	103,757	0.000000	90.04
90.05	09005	DR BLASER		0	0	0	175,143	0.000000	90.05
90.06	09006	DR. RONHOLM		0	0	0	63,232	0.000000	90.06
90.07	09007	DR. BARKOVIK		0	0	0	77,128	0.000000	90.07
90.08	04950	NP LANGSTON		0	0	0	129,624	0.000000	90.08
90.09	09008	OP NURSING SERVICE		0	0	0	584,230	0.000000	90.09
90.10	09009	DR. RAJU		0	0	0	18,083	0.000000	90.10
91.00	09100	EMERGENCY		0	0	0	8,752,638	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	964,593	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		0	0	0	64,297,239		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1346 Component CCN: 14-5499		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 8/26/2020 3:56 pm	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09002	WOUND CARE	0.000000	0	0	0	0	0	90.01
90.02	09003	PAIN MANAGEMENT	0.000000	0	0	0	0	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	0	0	0	0	90.03
90.04	09004	DR. SKOW	0.000000	0	0	0	0	0	90.04
90.05	09005	DR. BLASER	0.000000	0	0	0	0	0	90.05
90.06	09006	DR. RONHOLM	0.000000	0	0	0	0	0	90.06
90.07	09007	DR. BARKOVIK	0.000000	0	0	0	0	0	90.07
90.08	04950	NP LANGSTON	0.000000	0	0	0	0	0	90.08
90.09	09008	OP NURSING SERVICE	0.000000	0	0	0	0	0	90.09
90.10	09009	DR. RAJU	0.000000	0	0	0	0	0	90.10
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/26/2020 3:56 pm

			Title XIX		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	0.752435	0	24,677	0	0	50.00	
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.129845	0	465,856	0	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.755219	0	15,755	0	0	55.00	
60.00	06000 LABORATORY	0.187326	0	269,023	0	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0.190440	0	65,033	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.448337	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.379506	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.549367	0	0	0	0	68.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255470	0	11,649	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.359558	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.261953	0	74,680	0	0	73.00	
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1.276443				0	88.00	
88.01	08801 RURAL HEALTH CLINIC II	1.671136				0	88.01	
90.00	09000 CLINIC	0.439400	0	0	0	0	90.00	
90.01	09002 WOUND CARE	0.394958	0	0	0	0	90.01	
90.02	09003 PAIN MANAGEMENT	1.243029	0	0	0	0	90.02	
90.03	09001 NEUROLOGY	0.000000	0	0	0	0	90.03	
90.04	09004 DR SKOW	3.474368	0	0	0	0	90.04	
90.05	09005 DR BLASER	1.232770	0	0	0	0	90.05	
90.06	09006 DR. RONHOLM	1.025826	0	0	0	0	90.06	
90.07	09007 DR. BARKOVIK	0.745942	0	0	0	0	90.07	
90.08	04950 NP LANGSTON	0.236530	0	0	0	0	90.08	
90.09	09008 OP NURSING SERVICE	0.243793	0	0	0	0	90.09	
90.10	09009 DR. RAJU	1.276503	0	0	0	0	90.10	
91.00	09100 EMERGENCY	0.387568	0	547,934	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.294578	0	17,305	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	106.644068	0	0			95.00	
200.00	Subtotal (see instructions)		0	1,491,912	0	0	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00	Net Charges (line 200 - line 201)		0	1,491,912	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
8/26/2020 3:56 pm

			Title XIX		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	18,568	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,489	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,898	0		55.00
60.00	06000	LABORATORY	50,395	0		60.00
65.00	06500	RESPIRATORY THERAPY	12,385	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,976	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,563	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09002	WOUND CARE	0	0		90.01
90.02	09003	PAIN MANAGEMENT	0	0		90.02
90.03	09001	NEUROLOGY	0	0		90.03
90.04	09004	DR. SKOW	0	0		90.04
90.05	09005	DR. BLASER	0	0		90.05
90.06	09006	DR. RONHOLM	0	0		90.06
90.07	09007	DR. BARKOVIK	0	0		90.07
90.08	04950	NP LANGSTON	0	0		90.08
90.09	09008	OP NURSING SERVICE	0	0		90.09
90.10	09009	DR. RAJU	0	0		90.10
91.00	09100	EMERGENCY	212,362	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,098	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	393,734	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	393,734	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 3:56 pm	
Cost Center Description		Title XVIII	Hospital	Cost	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,785	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,037	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)			1,664	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,596	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			152	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)			1,166	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)			1,596	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,827,876	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)			24,315	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)			1,255,932	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,571,944	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,571,944	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)			771.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			899,791	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)			899,791	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

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

Worksheet D-1

Date/Time Prepared:
8/26/2020 3:56 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	72,337	21	3,444.62	20	68,892
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)					1,055,378
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,024,061
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,231,617
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,231,617
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					373
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					771.70
89.00	Observation bed cost (line 87 x line 88) (see instructions)					287,844

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

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

Worksheet D-1

Date/Time Prepared:
8/26/2020 3:56 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	143,403	2,827,876	0.050710	287,844	14,597	90.00
91.00	Nursing School cost	0	2,827,876	0.000000	287,844	0	91.00
92.00	Allied health cost	0	2,827,876	0.000000	287,844	0	92.00
93.00	All other Medical Education	0	2,827,876	0.000000	287,844	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 3:56 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		16,902	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,902	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		16,902	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		152	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)		0	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		159.97	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		159.97	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,476,724	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)		24,315	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)		24,315	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,452,409	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,452,409	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 3:56 pm	
				Title XVIII		Skilled Nursing Facility	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		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)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					4,452,409	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					263.42	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

8/26/2020 3:56 pm

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

Period:

Worksheet D-1

Component CCN: 14-5499

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 pm

Title XVIII

Skilled Nursing
Facility

PPS

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 8/26/2020 3:56 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,785 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,037 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)			1,664 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,596 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			152 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			159.97 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			159.97 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,827,876 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)			24,315 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)			1,255,932 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,571,944 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,571,944 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)			771.69 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			21,607 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)			21,607 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

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

Worksheet D-1

Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	72,337	21	3,444.62	0	0	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)					31,073	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					52,680	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)					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)					373	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					771.70	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					287,844	89.00

8/26/2020 3:56 pm

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1346

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

Worksheet D-1

Date/Time Prepared:
8/26/2020 3:56 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	143,403	2,827,876	0.050710	287,844	14,597	90.00
91.00	Nursing School cost	0	2,827,876	0.000000	287,844	0	91.00
92.00	Allied health cost	0	2,827,876	0.000000	287,844	0	92.00
93.00	All other Medical Education	0	2,827,876	0.000000	287,844	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/26/2020 3:56 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		1,469,189	30.00
31.00	03100	INTENSIVE CARE UNIT		40,340	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.748444	111,568	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129845	407,287	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.755219	34,188	55.00
60.00	06000	LABORATORY	0.187326	808,008	60.00
65.00	06500	RESPIRATORY THERAPY	0.190440	310,192	65.00
66.00	06600	PHYSICAL THERAPY	0.448337	103,361	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379506	16,154	67.00
68.00	06800	SPEECH PATHOLOGY	0.549367	24,113	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255470	621,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.359558	612,620	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261953	896,661	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
90.00	09000	CLINIC	0.439400	0	90.00
90.01	09002	WOUND CARE	0.394958	3,861	90.01
90.02	09003	PAIN MANAGEMENT	1.243029	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	90.03
90.04	09004	DR SKOW	3.474368	0	90.04
90.05	09005	DR BLASER	1.232770	0	90.05
90.06	09006	DR. RONHOLM	1.025826	0	90.06
90.07	09007	DR. BARKOVIK	0.745942	0	90.07
90.08	04950	NP LANGSTON	0.236530	0	90.08
90.09	09008	OP NURSING SERVICE	0.243793	0	90.09
90.10	09009	DR. RAJU	1.276503	0	90.10
91.00	09100	EMERGENCY	0.387568	2,705	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.298410	2,046	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,953,898	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)		3,953,898	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3
			Component CCN: 14-Z346		Date/Time Prepared: 8/26/2020 3:56 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
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.748444	4,714	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129845	137,971	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.755219	13,965	55.00
60.00	06000	LABORATORY	0.187326	435,980	60.00
65.00	06500	RESPIRATORY THERAPY	0.190440	266,051	65.00
66.00	06600	PHYSICAL THERAPY	0.448337	387,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379506	124,032	67.00
68.00	06800	SPEECH PATHOLOGY	0.549367	68,827	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255470	320,586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.359558	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261953	948,323	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	88.01
90.00	09000	CLINIC	0.439400	0	90.00
90.01	09002	WOUND CARE	0.394958	557	90.01
90.02	09003	PAIN MANAGEMENT	1.243029	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	90.03
90.04	09004	DR SKOW	3.474368	0	90.04
90.05	09005	DR BLASER	1.232770	0	90.05
90.06	09006	DR. RONHOLM	1.025826	0	90.06
90.07	09007	DR. BARKOVIK	0.745942	0	90.07
90.08	04950	NP LANGSTON	0.236530	0	90.08
90.09	09008	OP NURSING SERVICE	0.243793	0	90.09
90.10	09009	DR. RAJU	1.276503	0	90.10
91.00	09100	EMERGENCY	0.387568	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.298410	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,708,564	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,708,564	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 8/26/2020 3:56 pm
			Title XIX	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		34,101	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.752435	7,304	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129845	5,498	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.755219	0	55.00
60.00	06000	LABORATORY	0.187326	11,502	60.00
65.00	06500	RESPIRATORY THERAPY	0.190440	3,159	65.00
66.00	06600	PHYSICAL THERAPY	0.448337	2,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.379506	841	67.00
68.00	06800	SPEECH PATHOLOGY	0.549367	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.255470	66,263	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.359558	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.261953	14,060	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.276443	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.671136	0	88.01
90.00	09000	CLINIC	0.439400	0	90.00
90.01	09002	WOUND CARE	0.394958	0	90.01
90.02	09003	PAIN MANAGEMENT	1.243029	0	90.02
90.03	09001	NEUROLOGY	0.000000	0	90.03
90.04	09004	DR SKOW	3.474368	0	90.04
90.05	09005	DR BLASER	1.232770	0	90.05
90.06	09006	DR. RONHOLM	1.025826	0	90.06
90.07	09007	DR. BARKOVIK	0.745942	0	90.07
90.08	04950	NP LANGSTON	0.236530	0	90.08
90.09	09008	OP NURSING SERVICE	0.243793	0	90.09
90.10	09009	DR. RAJU	1.276503	0	90.10
91.00	09100	EMERGENCY	0.387568	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.294578	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		111,249	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)		111,249	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 8/26/2020 3:56 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,004,357	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)		7,004,357	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		7,074,401	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)		66,713	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,725,298	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)		3,282,390	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)		3,282,390	30.00
31.00	Primary payer payments		195	31.00
32.00	Subtotal (line 30 minus line 31)		3,282,195	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)		904,368	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		587,839	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		565,508	36.00
37.00	Subtotal (see instructions)		3,870,034	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)		3,870,034	40.00
40.01	Sequestration adjustment (see instructions)		77,401	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		3,631,055	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)		161,578	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		1,177,402	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: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
8/26/2020 3:56 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		1,695,719		3,493,955	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	08/08/2019	137,100	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		137,100	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)		1,695,719		3,631,055	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		53,507		161,578	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,749,226		3,792,633	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: 14-1346

Period:

Worksheet E-1

Component CCN: 14-Z346

From 01/01/2019
To 12/31/2019Part I
Date/Time Prepared:
8/26/2020 3:56 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		1,791,276		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	08/08/2019	34,500		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)		34,500		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)		1,825,776		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		103,041		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,928,817		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: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part II
Date/Time Prepared:
8/26/2020 3:56 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: 14-1346

Period:

Worksheet E-2

Component CCN: 14-Z346

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 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)		1,243,933	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)		761,037	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		1,596	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2,004,970	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		2,004,970	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2,004,970	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		36,789	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,968,181	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,968,181	0	19.00
19.01	Sequestration adjustment (see instructions)		39,364	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		1,825,776	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		103,041	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1346	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 8/26/2020 3:56 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,024,061	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)		2,024,061	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,044,302	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)		2,044,302	19.00
20.00	Deductibles (exclude professional component)		313,720	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		1,730,582	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,730,582	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		83,603	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		54,342	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		56,523	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		1,784,924	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)		1,784,924	30.00
30.01	Sequestration adjustment (see instructions)		35,698	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		1,695,719	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)		53,507	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		29,261	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VI Date/Time Prepared: 8/26/2020 3:56 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet E-3
Part VII
Date/Time Prepared:
8/26/2020 3:56 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		52,680		1.00
2.00	Medical and other services			393,734	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		53,207	397,671	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		53,207	397,671	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		111,249	1,491,912	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		111,249	1,491,912	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		111,249	1,491,912	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		58,042	1,094,241	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		53,207	397,671	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		53,207	397,671	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		53,207	397,671	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		53,207	397,671	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		53,207	397,671	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		53,207	397,671	40.00
41.00	Interim payments		53,207	397,671	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1346 Component CCN: 14-5499	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 8/26/2020 3:56 pm
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-1346

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

Worksheet G

Date/Time Prepared:
8/26/2020 3:56 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	900,771	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	17,125,469	0	0	0	4.00
5.00 Other receivable	4,660	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-12,825,694	0	0	0	6.00
7.00 Inventory	432,273	0	0	0	7.00
8.00 Prepaid expenses	201,771	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	16,667	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	5,855,917	0	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	0	0	0	0	15.00
16.00 Accumulated depreciation	0	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	6,274,104	0	0	0	23.00
24.00 Accumulated depreciation	-4,884,908	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	1,898,111	0	0	0	27.00
28.00 Accumulated depreciation	-1,874,788	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)	1,412,519	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	392,015	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	392,015	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	7,660,451	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	2,680,920	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,168,207	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	824,211	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	0	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	4,673,338	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	1,115,252	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	1,115,252	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	5,788,590	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	1,871,861				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)	1,871,861	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	7,660,451	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1346

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

Worksheet G-1

Date/Time Prepared:
8/26/2020 3:56 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		2,238,446		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-366,585				2.00
3.00	Total (sum of line 1 and line 2)		1,871,861		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)		1,871,861		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)		1,871,861		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: 14-1346

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
8/26/2020 3:56 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,508,144		3,508,144	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	2,907,227		2,907,227	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,415,371		6,415,371	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	60,290		60,290	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)	60,290		60,290	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,475,661		6,475,661	17.00
18.00	Ancillary services	9,013,063	42,586,328	51,599,391	18.00
19.00	Outpatient services	4,590	10,619,285	10,623,875	19.00
20.00	RURAL HEALTH CLINIC	77,845	1,175,099	1,252,944	20.00
20.01	RURAL HEALTH CLINIC II	0	177,721	177,721	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	118	118	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER CLINIC REVENUE	0	0	0	27.00
27.01	OBSERVATION	1,909	975,854	977,763	27.01
27.02	CLINIC	0	2,288,832	2,288,832	27.02
27.03	WOUND CARE	-290	519,069	518,779	27.03
27.04	PAIN MANAGEMENT	0	287,605	287,605	27.04
27.05	NEUROLOGY	0	0	0	27.05
27.06	DR SKOW	153,385	368,749	522,134	27.06
27.07	DR BLASER	95,980	2,172,505	2,268,485	27.07
27.08	DR RONHOLM	0	91,281	91,281	27.08
27.09	DR BARKOVIK	4,787	130,508	135,295	27.09
27.10	NP DIEDRE	148,879	257,403	406,282	27.10
27.11	PHYSICIAN REVENUE	1,325	1,260,244	1,261,569	27.11
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,977,134	62,910,601	78,887,735	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,442,747		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)		30,442,747		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1346

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

Worksheet G-3

Date/Time Prepared:
8/26/2020 3:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	78,887,735	1.00
2.00	Less contractual allowances and discounts on patients' accounts	51,319,100	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,568,635	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,442,747	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,874,112	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	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	89,493	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,266	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,416,768	24.00
25.00	Total other income (sum of lines 6-24)	2,507,527	25.00
26.00	Total (line 5 plus line 25)	-366,585	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)	-366,585	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346

Period:

Worksheet M-1

Component CCN: 14-8527

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 pm

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	256,486	256,486	1.00
2.00	Physician Assistant	0	0	149,625	149,625	2.00
3.00	Nurse Practitioner	0	0	159,812	159,812	3.00
4.00	Visiting Nurse	0	0	0	0	4.00
5.00	Other Nurse	0	0	108,768	108,768	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	24,228	24,228	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	0	698,919	698,919	10.00
11.00	Physician Services Under Agreement	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	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	0	0	0	14.00
15.00	Medical Supplies	0	339	339	339	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	339	339	339	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	339	339	699,258	22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	274	274	274	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	274	274	274	28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	34,699	34,699	34,699	29.00
30.00	Administrative Costs	846,080	94,258	940,338	-698,919	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	846,080	128,957	975,037	-698,919	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	846,080	129,570	975,650	975,650	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346

Period:

Worksheet M-1

Component CCN: 14-8527

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 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	256,486	1.00
2.00	Physician Assistant	0	149,625	2.00
3.00	Nurse Practitioner	0	159,812	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	108,768	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	24,228	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	698,919	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	339	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	339	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	699,258	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	274	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	274	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	34,699	29.00
30.00	Administrative Costs	-758	240,661	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-758	275,360	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-758	974,892	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346

Period:

Worksheet M-1

Component CCN: 14-8528

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0
2.00	Physician Assistant	0	0	0	47,235	47,235
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	64,462	64,462
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	111,697	111,697
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	29	29	0	29
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	29	29	0	29
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	29	29	111,697	111,726
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	40,589	40,589	0	40,589
30.00	Administrative Costs	124,687	29,677	154,364	-111,697	42,667
31.00	Total Facility Overhead (sum of lines 29 and 30)	124,687	70,266	194,953	-111,697	83,256
32.00	Total facility costs (sum of lines 22, 28 and 31)	124,687	70,295	194,982	0	194,982

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1346

Period:

Worksheet M-1

Component CCN: 14-8528

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 pm

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	47,235	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	64,462	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	111,697	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	29	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	111,726	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	40,589	29.00
30.00	Administrative Costs	0	42,667	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	83,256	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	194,982	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1346

Period:

Worksheet M-2

Component CCN: 14-8527

From 01/01/2019

To 12/31/2019

Date/Time Prepared:
8/26/2020 3:56 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	1.07	1,699	4,200	4,494		1.00
2.00	Physician Assistant	1.04	2,527	2,100	2,184		2.00
3.00	Nurse Practitioner	1.34	3,593	2,100	2,814		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.45	7,819		9,492	9,492	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)	3.45	7,819			9,492	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)					699,258	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					274	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					699,532	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999608	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					275,360	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					624,420	15.00
16.00	Total overhead (sum of lines 14 and 15)					899,780	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					899,780	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					899,427	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,598,685	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1346

Period:

Worksheet M-2

Component CCN: 14-8528

From 01/01/2019
To 12/31/2019Date/Time Prepared:
8/26/2020 3:56 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.34	1,316	2,100	714		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.34	1,316		714	1,316	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.34	1,316			1,316	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)					111,726	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)					111,726	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)					83,256	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					102,014	15.00
16.00	Total overhead (sum of lines 14 and 15)					185,270	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					185,270	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					185,270	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					296,996	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1346 Component CCN: 14-8527	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/26/2020 3:56 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)			1,598,685	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,598,685	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,492	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)			9,492	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			168.42	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)			83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)			168.42	168.42	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	1,792	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	301,809	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	301,809	16.00
16.01	Total program charges (see instructions)(from contractor's records)				296,766	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				12,487	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				12,699	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.)				207,407	16.04
16.05	Total program cost (see instructions)			0	220,106	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				29,851	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				50,886	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				220,106	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				220,106	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)				220,106	26.00
26.01	Sequestration adjustment (see instructions)				4,402	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				215,026	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)				678	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1346 Component CCN: 14-8528	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 8/26/2020 3:56 pm	
			Title XVIII	RHC II	Cost
					1.00
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			296,996	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			296,996	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,316	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)			1,316	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			225.68	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		225.68	225.68	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	368	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	83,050	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	83,050	16.00
16.01	Total program charges (see instructions)(from contractor's records)			57,134	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			9,286	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			13,498	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.)			50,489	16.04
16.05	Total program cost (see instructions)		0	63,987	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			6,441	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			8,281	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			63,987	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			63,987	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)			63,987	26.00
26.01	Sequestration adjustment (see instructions)			1,280	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			50,498	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			12,209	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1346 Component CCN: 14-8527	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/26/2020 3:56 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			215,026	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)			215,026	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			678	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			215,704	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1346 Component CCN: 14-8528	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 8/26/2020 3:56 pm	
		RHC II	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		50,498	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)		50,498	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		12,209	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		62,707	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00