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: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/8/2020 8:34 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 6/8/2020 Time: 8:34 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] 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 PERRY COUNTY HOSPITAL (15-1322) 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)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	597,602	-417,085	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	651,658	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-135,322		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-8,265		0	10.01
10.02	RURAL HEALTH CLINIC III	0		46,932		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		0		0	10.03
200.00	Total	0	1,249,260	-513,740	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 8:34 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8885 SR 237	PO Box: X			1.00
2.00	City: TELL CITY	State: IN	Zip Code: 47586	County: PERRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PERRY COUNTY HOSPITAL	151322	99915	1	07/01/2004	N	O	P	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	PERRY COUNTY HOSPITAL SWING	15Z322	99915		07/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PERRY COUNTY HOSPITAL HHA	157177	99915		06/13/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	TELL CITY CLINIC	158516	99915		05/18/2015	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	PERRY CO FAMILY PRACTICE	158517	99915		05/19/2015	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	TROY CLINIC	158518	99915		11/23/2015	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	CANNELTON CLINIC	158519	99915		05/06/2016	N	O	N	15.03
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)	9		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 6/8/2020 8:34 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		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.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 8:34 am

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 8:34 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 8:34 am

		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.	Y	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	285,544	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	5.01	122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 8:34 am

		1.00	2.00	
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

	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.			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.	N		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	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/8/2020 8:34 am

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 6/8/2020 8:34 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	R		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	02/28/2020	Y	02/28/2020	17.00
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: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 6/8/2020 8:34 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	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.	CLINT	BRILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923500	CBRILL@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/8/2020 8:34 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 6/8/2020 8:34 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	37,032.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	37,032.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	37,032.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/8/2020 8:34 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	932	60	1,647			1.00
2.00	HMO and other (see instructions)	151	204				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	706	0	706			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	163			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,638	60	2,516			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		8	99			13.00
14.00	Total (see instructions)	1,638	68	2,615	0.00	214.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,883	0	6,538	0.00	10.55	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,402	0	15,211	0.00	24.55	26.00
26.01	RURAL HEALTH CLINIC II	167	0	3,429	0.00	4.80	26.01
26.02	RURAL HEALTH CLINIC III	515	0	2,734	0.00	2.96	26.02
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	257.46	27.00
28.00	Observation Bed Days		0	530			28.00
29.00	Ambulance Trips	1,031					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	1	30			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: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 6/8/2020 8:34 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	294	20	562	1.00
2.00	HMO and other (see instructions)			41	55		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	294	20	562	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-4 | Date/Time Prepared: 6/8/2020 8:34 am

Home Health Agency I | PPS

						1.00	
0.00	County				PERRY		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,995	482	451	3,928	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	199.00	32.00	30.00	261.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.88	0.00	0.88	5.00
6.00	Direct Nursing Service			2.92	0.00	2.92	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.89	0.00	1.89	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	846	138	20	37	1,041	21.00
22.00	Skilled Nursing Visit Charges	402,870	65,370	9,438	18,416	496,094	22.00
23.00	Physical Therapy Visits	1,148	303	1	9	1,461	23.00
24.00	Physical Therapy Visit Charges	394,082	104,122	344	3,096	501,644	24.00
25.00	Occupational Therapy Visits	738	243	0	1	982	25.00
26.00	Occupational Therapy Visit Charges	221,094	72,801	0	300	294,195	26.00
27.00	Speech Pathology Visits	93	83	0	0	176	27.00
28.00	Speech Pathology Visit Charges	31,912	28,472	0	0	60,384	28.00
29.00	Medical Social Service Visits	0	5	0	0	5	29.00
30.00	Medical Social Service Visit Charges	0	1,955	0	0	1,955	30.00
31.00	Home Health Aide Visits	152	65	1	0	218	31.00
32.00	Home Health Aide Visit Charges	37,892	16,178	249	0	54,319	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,977	837	22	47	3,883	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,087,850	288,898	10,031	21,812	1,408,591	35.00
36.00	Total Number of Episodes (standard/non outlier)	170		10	6	186	36.00
37.00	Total Number of Outlier Episodes		20		0	20	37.00
38.00	Total Non-Routine Medical Supply Charges	45,918	2,481	4,725	1,656	54,780	38.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 6/8/2020 8:34 am

			RHC I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		109 IN-66	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	TELL CITY	IN	47586 2.00
				1.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0 3.00
		Grant Award		Date
		1.00		2.00
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00
			1.00	2.00
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0 10.00

		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	CLINIC			06:30	17:00	06:30 11.00

			1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?		N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N	0 13.00
		Provider name		CCN number
		1.00		2.00
14.00	RHC/FQHC name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits
		1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00

			County			
			4.00			
2.00	City, State, ZIP Code, County		PERRY			2.00

		Tuesday	Wednesday		Thursday	
		to	from	to	from	to
		6.00	7.00	8.00	9.00	10.00
	Facility hours of operations (1)					
11.00	CLINIC	17:00	06:30	17:00	06:30	17:00 11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322
Component CCN: 15-8516

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

Worksheet S-8
Date/Time Prepared:
6/8/2020 8:34 am

RHC I | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	06:30	16:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 6/8/2020 8:34 am

RHC II | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			315 MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	TROY		IN	47588	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			08:00	17:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN number	
				1.00	2.00	
14.00	RHC/FQHC name, CCN number					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		PERRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	10:00	19:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322
Component CCN: 15-8517

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

Worksheet S-8
Date/Time Prepared:
6/8/2020 8:34 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	08:00	12:00				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-8 | Date/Time Prepared: 6/8/2020 8:34 am

				RHC III	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			18485 OLD STATE ROAD 37		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	LEOPOLD		IN	47551	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			07:00	16:00	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	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

			County				
			4.00				
2.00	City, State, ZIP Code, County		PERRY				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	16:00	07:00	11:00	07:00	16:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 15-1322
Component CCN: 15-8518

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

Worksheet S-8
Date/Time Prepared:
6/8/2020 8:34 am

RHC III | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	07:00	15:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet S-10 Date/Time Prepared: 6/8/2020 8:34 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.345305	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,963,367	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	13,954,176	6.00
7.00	Medicaid cost (line 1 times line 6)	4,818,447	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)	1,855,080	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)	1,855,080	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)	660,406	0	660,406	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	228,041	0	228,041	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	228,041	0	228,041	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,672,743	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	721,085	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,109,361	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,563,382	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	928,120	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,156,161	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,011,241	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		2,568,424	2,568,424	81,418	2,649,842	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,171,672	1,171,672	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	122,273	2,608,017	2,730,290	-262	2,730,028	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	980,586	2,612,728	3,593,314	-28,882	3,564,432	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	1,121,507	2,130,890	3,252,397	-7,876	3,244,521	5.02
7.00	00700	OPERATION OF PLANT	257,042	1,365,273	1,622,315	-4,743	1,617,572	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,921	80,921	0	80,921	8.00
9.00	00900	HOUSEKEEPING	270,945	97,485	368,430	0	368,430	9.00
10.00	01000	DIETARY	0	648,614	648,614	-507,338	141,276	10.00
11.00	01100	CAFETERIA	0	0	0	507,076	507,076	11.00
13.00	01300	NURSING ADMINISTRATION	237,542	1,983	239,525	0	239,525	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	171,072	64,652	235,724	-1,016	234,708	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,641,785	1,501,164	3,142,949	408,007	3,550,956	30.00
31.00	03100	INTENSIVE CARE UNIT	257,044	156,772	413,816	-413,816	0	31.00
43.00	04300	NURSERY	29,396	0	29,396	0	29,396	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	428,736	1,230,852	1,659,588	-180,412	1,479,176	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,676	177,713	206,389	0	206,389	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	810,127	384,216	1,194,343	-958	1,193,385	54.00
60.00	06000	LABORATORY	720,295	1,169,306	1,889,601	-696	1,888,905	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,435	63,071	64,506	0	64,506	62.00
65.00	06500	RESPIRATORY THERAPY	471,715	380,710	852,425	-36,343	816,082	65.00
66.00	06600	PHYSICAL THERAPY	417,470	110,502	527,972	-424	527,548	66.00
67.00	06700	OCCUPATIONAL THERAPY	159,939	25,804	185,743	0	185,743	67.00
68.00	06800	SPEECH PATHOLOGY	89,264	11,544	100,808	0	100,808	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	414,927	414,927	255,972	670,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	145,869	145,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,456	2,858,143	2,935,599	-61,172	2,874,427	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,876,009	993,139	2,869,148	11,298	2,880,446	88.00
88.01	08801	RURAL HEALTH CLINIC II	421,694	248,035	669,729	-75,603	594,126	88.01
88.02	08803	RURAL HEALTH CLINIC III	162,317	265,381	427,698	-1,937	425,761	88.02
88.03	08802	RURAL HEALTH CLINIC IV	13,987	4,585	18,572	0	18,572	88.03
90.00	09000	CLINIC	311,851	86,290	398,141	66,600	464,741	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	188,695	105,927	294,622	93,694	388,316	90.02
90.03	09003	ORTHOPEDIC CLINIC	79,731	8,339	88,070	-2,735	85,335	90.03
91.00	09100	EMERGENCY	684,936	1,281,261	1,966,197	-2,566	1,963,631	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	722,743	320,137	1,042,880	-22,176	1,020,704	95.00
101.00	10100	HOME HEALTH AGENCY	629,580	195,291	824,871	0	824,871	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,171,672	1,171,672	-1,171,672	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,385,848	25,343,768	38,729,616	220,979	38,950,595	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	1,072,721	273,575	1,346,296	-220,979	1,125,317	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	14,458,569	25,617,343	40,075,912	0	40,075,912	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 6/8/2020 8:34 am

		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	-37,459	2,612,383		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-36,535	1,135,137		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,730,028		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	-1,108,952	2,455,480		5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	0	3,244,521		5.02
7.00	00700	OPERATION OF PLANT	-891	1,616,681		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	80,921		8.00
9.00	00900	HOUSEKEEPING	0	368,430		9.00
10.00	01000	DIETARY	-517	140,759		10.00
11.00	01100	CAFETERIA	-104,718	402,358		11.00
13.00	01300	NURSING ADMINISTRATION	0	239,525		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,543	231,165		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-240,875	3,310,081		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	29,396		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-826,465	652,711		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-177,713	28,676		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-46,196	1,147,189		54.00
60.00	06000	LABORATORY	0	1,888,905		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	64,506		62.00
65.00	06500	RESPIRATORY THERAPY	-251,084	564,998		65.00
66.00	06600	PHYSICAL THERAPY	0	527,548		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	185,743		67.00
68.00	06800	SPEECH PATHOLOGY	0	100,808		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	670,899		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	145,869		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,341	2,873,086		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-10,369	2,870,077		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	594,126		88.01
88.02	08803	RURAL HEALTH CLINIC III	0	425,761		88.02
88.03	08802	RURAL HEALTH CLINIC IV	-18,572	0		88.03
90.00	09000	CLINIC	-25,500	439,241		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
90.02	09002	WOUND CARE	-128,414	259,902		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	85,335		90.03
91.00	09100	EMERGENCY	0	1,963,631		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,165	1,019,539		95.00
101.00	10100	HOME HEALTH AGENCY	0	824,871		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,020,309	35,930,286		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,125,317		192.00
192.01	19201	MARKETING	0	0		192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,020,309	37,055,603		200.00

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/8/2020 8:34 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA COST				
1.00	CAFETERIA	11.00	0	507,076	1.00
	0		0	507,076	
	B - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,171,672	1.00
	0		0	1,171,672	
	C - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	44,113	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	44,113	
	D - INSURANCE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	37,305	1.00
2.00		0.00	0	0	2.00
	0		0	37,305	
	E - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,327	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	6,327	
	F - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	401,841	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	401,841	
	G - IMPLANTABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	145,869	1.00
	0		0	145,869	
	H - WOUND CARE RECLASS				
1.00	WOUND CARE	90.02	105,887	0	1.00
	0		105,887	0	
	I - RHC RECRUITING EXPENSE RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	0	5,769	1.00
	TOTALS		0	5,769	
	J - IV THERAPY				
1.00	CLINIC	90.00	0	67,237	1.00
	0		0	67,237	
	K - SURGEON RECLASS				
1.00	OPERATING ROOM	50.00	187,103	0	1.00
	0		187,103	0	
	L - TELL CITY RECLASS				
1.00	RURAL HEALTH CLINIC	88.00	5,529	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	72,011	0	2.00
	TOTALS		77,540	0	
	M - ICU RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	257,044	156,352	1.00
	TOTALS		257,044	156,352	
500.00	Grand Total: Increases		627,574	2,543,561	500.00

RECLASSIFICATIONS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 6/8/2020 8:34 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA COST						
1.00	DIETARY	10.00	0	507,076	0		1.00
	0		0	507,076			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,171,672	11		1.00
	0		0	1,171,672			
	C - LEASE EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	262	9		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	1,600	0		2.00
3.00	ADMINISTRATIVE AND GENERAL - OTHER	5.02	0	7,876	0		3.00
4.00	OPERATION OF PLANT	7.00	0	4,743	0		4.00
5.00	DIETARY	10.00	0	262	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,016	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2,605	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	294	0		8.00
9.00	OPERATING ROOM	50.00	0	915	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	958	0		10.00
11.00	LABORATORY	60.00	0	696	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	15,885	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	262	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	262	0		14.00
15.00	CLINIC	90.00	0	637	0		15.00
16.00	WOUND CARE	90.02	0	262	0		16.00
17.00	EMERGENCY	91.00	0	1,119	0		17.00
18.00	AMBULANCE SERVICES	95.00	0	4,459	0		18.00
	0		0	44,113			
	D - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	19,588	10		1.00
2.00	AMBULANCE SERVICES	95.00	0	17,717	0		2.00
	0		0	37,305			
	E - DRUGS CHARGED						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	1,925	0		1.00
2.00	WOUND CARE	90.02	0	1,667	0		2.00
3.00	ORTHOPEDIC CLINIC	90.03	0	2,735	0		3.00
	0		0	6,327			
	F - BILLABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	2,784	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	126	0		2.00
3.00	OPERATING ROOM	50.00	0	366,600	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	20,458	0		4.00
5.00	PHYSICAL THERAPY	66.00	0	162	0		5.00
6.00	WOUND CARE	90.02	0	10,264	0		6.00
7.00	EMERGENCY	91.00	0	1,447	0		7.00
	0		0	401,841			
	G - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	145,869	0		1.00
	0		0	145,869			
	H - WOUND CARE RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	105,887	0	0		1.00
	0		105,887	0			
	I - RHC RECRUITING EXPENSE RECLASS						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	5,769	0		1.00
	TOTALS		0	5,769			
	J - IV THERAPY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	67,237	0		1.00
	0		0	67,237			
	K - SURGEON RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	187,103	0	0		1.00
	0		187,103	0			
	L - TELL CITY RECLASS						
1.00	RURAL HEALTH CLINIC II	88.01	75,603	0	0		1.00
2.00	RURAL HEALTH CLINIC III	88.02	1,937	0	0		2.00
	TOTALS		77,540	0			
	M - ICU RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	257,044	156,352	0		1.00
	TOTALS		257,044	156,352			
500.00	Grand Total: Decreases		627,574	2,543,561			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 6/8/2020 8:34 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,755,753	1,060,000	0	1,060,000	0	1.00
2.00	Land Improvements	73,301	0	0	0	6,971	2.00
3.00	Buildings and Fixtures	3,275,626	40,747,835	0	40,747,835	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	171,558	2,159,159	0	2,159,159	0	5.00
6.00	Movable Equipment	11,167,498	5,554,389	0	5,554,389	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,443,736	49,521,383	0	49,521,383	6,971	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,443,736	49,521,383	0	49,521,383	6,971	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,815,753	0	1.00
2.00	Land Improvements	66,330	0	2.00
3.00	Buildings and Fixtures	44,023,461	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,330,717	0	5.00
6.00	Movable Equipment	16,721,887	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,958,148	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	66,958,148	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II Date/Time Prepared: 6/8/2020 8:34 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,479,112	0	0	89,457	-145	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,479,112	0	0	89,457	-145	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,568,424		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,568,424		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 6/8/2020 8:34 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	50,236,261	0	50,236,261	0.750264	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	16,721,887	0	16,721,887	0.249736	0	2.00
3.00	Total (sum of lines 1-2)	66,958,148	0	66,958,148	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	2,485,766	37,305	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	-36,535	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,485,766	770	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	89,457	-145	0	2,612,383	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,171,672	0	0	0	1,135,137	2.00
3.00	Total (sum of lines 1-2)	1,171,672	89,457	-145	0	3,747,520	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/8/2020 8:34 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		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)	B	-101,885	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-6,378	ADMINISTRATIVE AND GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-891	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,695,385			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	65,350			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-104,718	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-89,559	ADMINISTRATIVE AND GENERAL	5.01	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	B	-1,341	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,543	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-517	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 6/8/2020 8:34 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-37,459	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	ADMINISTRATION MISCELLANEOUS REVENUE	B	-163,216	ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01	AMBULANCE MISC REVENUE	B	-1,165	AMBULANCE SERVICES	95.00	0	33.01
33.02	RHC I MISC REVENUE	B	-10,199	RURAL HEALTH CLINIC	88.00	0	33.02
33.03	WOUND CENTER-ADVERTISING	A	-862	WOUND CARE	90.02	0	33.03
33.04	ADMINISTRATION-CONTRIBUTIONS	A	-12,271	ADMINISTRATIVE AND GENERAL	5.01	0	33.04
33.05	ADVERTISING - TELL CITY	A	-170	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	HAF FEES	B	-833,291	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	LOBBYING DUES	A	-4,237	ADMINISTRATIVE AND GENERAL	5.01	0	33.07
33.08	CANNELTON OFFSET	A	-18,572	RURAL HEALTH CLINIC IV	88.03	0	33.08
33.09	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,020,309				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: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-1 | Date/Time Prepared: 6/8/2020 8:34 am

	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	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	65,350	0	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	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			65,350	0	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B	PERRY CO AMBULA	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

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.

(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: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-1 Date/Time Prepared: 6/8/2020 8:34 am

	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	65,350	10		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	65,350			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: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 6/8/2020 8:34 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	919,196	240,875	678,321	0	0	1.00
2.00	50.00	OPERATING ROOM	826,465	826,465	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	177,713	177,713	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	46,196	46,196	0	0	0	4.00
5.00	60.00	LABORATORY	6,000	0	6,000	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	251,084	251,084	0	0	0	6.00
7.00	90.00	CLINIC	25,500	25,500	0	0	0	7.00
8.00	90.02	WOUND CARE	127,552	127,552	0	0	0	8.00
9.00	91.00	EMERGENCY	1,124,698	0	1,124,698	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,504,404	1,695,385	1,809,019		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	90.02	WOUND CARE	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	240,875		1.00
2.00	50.00	OPERATING ROOM	0	0	0	826,465		2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	177,713		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	46,196		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	251,084		6.00
7.00	90.00	CLINIC	0	0	0	25,500		7.00
8.00	90.02	WOUND CARE	0	0	0	127,552		8.00
9.00	91.00	EMERGENCY	0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,695,385		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 6/8/2020 8:34 am

Physical Therapy — Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	52	1.00
2.00	Line 1 multiplied by 15 hours per week	780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	460.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	84.94	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.47	42.47	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	39,136	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	39,136	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	39,136	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	84.94	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	66,253	22.00
23.00	Total salary equivalency (see instructions)	66,253	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 6/8/2020 8:34 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.94	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	66,253		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	2,364		61.00
62.00	Supplies (see instructions)	9,644		62.00
63.00	Total allowance (sum of lines 57-62)	78,261		63.00
64.00	Total cost of outside supplier services (from your records)	30,878		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,612,383	2,612,383				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,135,137		1,135,137			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,730,028	12,324	5,355	2,747,707		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,455,480	199,366	86,629	207,738	2,949,213	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	3,244,521	164,739	71,582	237,592	3,718,434	5.02
7.00	00700	OPERATION OF PLANT	1,616,681	499,781	217,165	54,455	2,388,082	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	80,921	4,265	1,853	0	87,039	8.00
9.00	00900	HOUSEKEEPING	368,430	28,679	12,462	57,400	466,971	9.00
10.00	01000	DIETARY	140,759	108,788	47,271	0	296,818	10.00
11.00	01100	CAFETERIA	402,358	0	0	0	402,358	11.00
13.00	01300	NURSING ADMINISTRATION	239,525	5,757	2,502	50,324	298,108	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	231,165	31,984	13,898	36,242	313,289	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,310,081	378,946	164,660	402,272	4,255,959	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	29,396	15,480	6,726	6,228	57,830	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	652,711	278,537	121,031	130,466	1,182,745	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,676	68,339	29,695	6,075	132,785	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,147,189	140,985	61,261	171,626	1,521,061	54.00
60.00	06000	LABORATORY	1,888,905	58,253	25,312	152,595	2,125,065	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	64,506	0	0	304	64,810	62.00
65.00	06500	RESPIRATORY THERAPY	564,998	87,593	38,061	99,933	790,585	65.00
66.00	06600	PHYSICAL THERAPY	527,548	43,072	18,716	88,441	677,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	185,743	18,700	8,126	33,883	246,452	67.00
68.00	06800	SPEECH PATHOLOGY	100,808	9,830	4,271	18,911	133,820	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	670,899	0	0	0	670,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	145,869	0	0	0	145,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,873,086	32,133	13,963	16,409	2,935,591	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,870,077	0	0	398,606	3,268,683	88.00
88.01	08801	RURAL HEALTH CLINIC II	594,126	0	0	73,320	667,446	88.01
88.02	08803	RURAL HEALTH CLINIC III	425,761	0	0	33,977	459,738	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	439,241	106,784	46,400	66,066	658,491	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	259,902	33,732	14,657	62,407	370,698	90.02
90.03	09003	ORTHOPEDIC CLINIC	85,335	0	0	16,891	102,226	90.03
91.00	09100	EMERGENCY	1,963,631	146,209	63,531	145,104	2,318,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,019,539	95,952	41,693	0	1,157,184	95.00
101.00	10100	HOME HEALTH AGENCY	824,871	12,538	5,448	0	842,857	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,930,286	2,582,766	1,122,268	2,567,265	35,707,358	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,617	12,869	0	42,486	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,125,317	0	0	180,442	1,305,759	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,055,603	2,612,383	1,135,137	2,747,707	37,055,603	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	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
5.01	00540	ADMINISTRATIVE AND GENERAL	2,949,213					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	321,537	4,039,971	4,039,971			5.02
7.00	00700	OPERATION OF PLANT	206,500	2,594,582	331,741	2,926,323		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,526	94,565	12,091	7,188	113,844	8.00
9.00	00900	HOUSEKEEPING	40,379	507,350	64,869	48,338	22,371	9.00
10.00	01000	DIETARY	25,666	322,484	41,232	183,362	0	10.00
11.00	01100	CAFETERIA	34,792	437,150	55,894	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,778	323,886	41,412	9,704	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	27,090	340,379	43,521	53,909	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	368,017	4,623,976	591,231	638,713	30,982	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	5,001	62,831	8,034	26,092	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	102,273	1,285,018	164,301	469,475	11,253	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,482	144,267	18,446	115,186	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	131,528	1,652,589	211,298	237,631	12,377	54.00
60.00	06000	LABORATORY	183,756	2,308,821	295,204	98,186	506	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,604	70,414	9,003	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	68,363	858,948	109,824	147,639	854	65.00
66.00	06600	PHYSICAL THERAPY	58,608	736,385	94,153	72,597	2,428	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,311	267,763	34,236	31,519	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,572	145,392	18,590	16,568	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,013	728,912	93,198	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,613	158,482	20,263	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	253,843	3,189,434	407,798	54,161	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	282,646	3,551,329	454,069	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	57,715	725,161	92,718	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	39,754	499,492	63,865	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	56,940	715,431	91,474	179,984	4,171	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	32,055	402,753	51,496	56,856	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	8,840	111,066	14,201	0	0	90.03
91.00	09100	EMERGENCY	200,481	2,518,956	322,071	246,436	28,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	100,063	1,257,247	160,750	161,727	202	95.00
101.00	10100	HOME HEALTH AGENCY	72,883	915,740	117,086	21,132	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,832,629	35,590,774	4,034,069	2,876,403	113,844	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,674	46,160	5,902	49,920	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	112,910	1,418,669	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,949,213	37,055,603	4,039,971	2,926,323	113,844	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	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
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	642,928					9.00
10.00	01000	DIETARY	41,065	588,143				10.00
11.00	01100	CAFETERIA	0	0	493,044			11.00
13.00	01300	NURSING ADMINISTRATION	2,173	0	1,177	378,352		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,073	0	15,795	0	465,677	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	143,045	588,143	149,420	219,514	117,874	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	5,843	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	105,141	0	32,239	47,348	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,796	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,218	0	54,895	0	23,284	54.00
60.00	06000	LABORATORY	21,989	0	59,524	0	23,284	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	33,064	0	33,701	0	32,015	65.00
66.00	06600	PHYSICAL THERAPY	16,259	0	24,159	0	5,821	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,059	0	11,085	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,710	0	4,872	0	5,821	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	12,130	0	14,942	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
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	40,308	0	28,625	42,052	132,427	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	12,733	0	15,348	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	55,190	0	47,262	69,438	125,151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	36,219	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	4,733	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	631,748	588,143	493,044	378,352	465,677	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,180	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)	642,928	588,143	493,044	378,352	465,677	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	ADMINISTRATIVE AND GENERAL					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	7,102,898	0	7,102,898		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	102,800	0	102,800		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,114,775	0	2,114,775		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	303,695	0	303,695		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,245,292	0	2,245,292		54.00
60.00	06000	LABORATORY	2,807,514	0	2,807,514		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,417	0	79,417		62.00
65.00	06500	RESPIRATORY THERAPY	1,216,045	0	1,216,045		65.00
66.00	06600	PHYSICAL THERAPY	951,802	0	951,802		66.00
67.00	06700	OCCUPATIONAL THERAPY	351,662	0	351,662		67.00
68.00	06800	SPEECH PATHOLOGY	194,953	0	194,953		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	822,110	0	822,110		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	178,745	0	178,745		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,678,465	0	3,678,465		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,005,398	0	4,005,398		88.00
88.01	08801	RURAL HEALTH CLINIC II	817,879	0	817,879		88.01
88.02	08803	RURAL HEALTH CLINIC III	563,357	0	563,357		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0		88.03
90.00	09000	CLINIC	1,234,472	0	1,234,472		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0		90.01
90.02	09002	WOUND CARE	539,186	0	539,186		90.02
90.03	09003	ORTHOPEDIC CLINIC	125,267	0	125,267		90.03
91.00	09100	EMERGENCY	3,413,204	0	3,413,204		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,616,145	0	1,616,145		95.00
101.00	10100	HOME HEALTH AGENCY	1,058,691	0	1,058,691		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,523,772	0	35,523,772		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	113,162	0	113,162		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,418,669	0	1,418,669		192.00
192.01	19201	MARKETING	0	0	0		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	37,055,603	0	37,055,603		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			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	12,324	5,355	17,679	17,679	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	0	199,366	86,629	285,995	1,337	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	0	164,739	71,582	236,321	1,529	5.02
7.00	00700	OPERATION OF PLANT	0	499,781	217,165	716,946	350	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,265	1,853	6,118	0	8.00
9.00	00900	HOUSEKEEPING	0	28,679	12,462	41,141	369	9.00
10.00	01000	DIETARY	0	108,788	47,271	156,059	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,757	2,502	8,259	324	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,984	13,898	45,882	233	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	378,946	164,660	543,606	2,586	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	15,480	6,726	22,206	40	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	278,537	121,031	399,568	839	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,339	29,695	98,034	39	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	140,985	61,261	202,246	1,104	54.00
60.00	06000	LABORATORY	0	58,253	25,312	83,565	982	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	2	62.00
65.00	06500	RESPIRATORY THERAPY	0	87,593	38,061	125,654	643	65.00
66.00	06600	PHYSICAL THERAPY	0	43,072	18,716	61,788	569	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,700	8,126	26,826	218	67.00
68.00	06800	SPEECH PATHOLOGY	0	9,830	4,271	14,101	122	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	32,133	13,963	46,096	106	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,565	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	472	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	219	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	106,784	46,400	153,184	425	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	33,732	14,657	48,389	402	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	109	90.03
91.00	09100	EMERGENCY	0	146,209	63,531	209,740	934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	95,952	41,693	137,645	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	12,538	5,448	17,986	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,582,766	1,122,268	3,705,034	16,518	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29,617	12,869	42,486	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,161	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,612,383	1,135,137	3,747,520	17,679	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	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
5.01	00540	ADMINISTRATIVE AND GENERAL	287,332					5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	31,328	269,178				5.02
7.00	00700	OPERATION OF PLANT	20,120	22,103	759,519			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	733	806	1,866	9,523		8.00
9.00	00900	HOUSEKEEPING	3,934	4,322	12,546	1,871	64,183	9.00
10.00	01000	DIETARY	2,501	2,747	47,591	0	4,099	10.00
11.00	01100	CAFETERIA	3,390	3,724	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,512	2,759	2,519	0	217	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,639	2,900	13,992	0	1,205	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,843	39,396	165,776	2,593	14,281	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	487	535	6,772	0	583	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,965	10,947	121,851	941	10,496	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,119	1,229	29,896	0	2,575	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,815	14,078	61,676	1,035	5,313	54.00
60.00	06000	LABORATORY	17,904	19,669	25,484	42	2,195	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	546	600	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	6,661	7,317	38,319	71	3,301	65.00
66.00	06600	PHYSICAL THERAPY	5,710	6,273	18,842	203	1,623	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,076	2,281	8,181	0	705	67.00
68.00	06800	SPEECH PATHOLOGY	1,127	1,239	4,300	0	370	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,652	6,210	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,229	1,350	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,732	27,171	14,057	0	1,211	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,539	30,254	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,623	6,178	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	3,873	4,255	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	5,548	6,095	46,714	349	4,024	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	3,123	3,431	14,757	0	1,271	90.02
90.03	09003	ORTHOPEDIC CLINIC	861	946	0	0	0	90.03
91.00	09100	EMERGENCY	19,533	21,459	63,962	2,401	5,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,749	10,710	41,976	17	3,616	95.00
101.00	10100	HOME HEALTH AGENCY	7,101	7,801	5,485	0	472	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	275,973	268,785	746,562	9,523	63,067	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	358	393	12,957	0	1,116	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,001	0	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)	287,332	269,178	759,519	9,523	64,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		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
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	212,997					10.00
11.00	01100	CAFETERIA	0	7,114				11.00
13.00	01300	NURSING ADMINISTRATION	0	17	16,607			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	228	0	67,079		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	212,997	2,156	9,635	16,979	1,045,848	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	30,623	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	465	2,078	0	557,150	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	132,892	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	792	0	3,354	302,413	54.00
60.00	06000	LABORATORY	0	859	0	3,354	154,054	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1,148	62.00
65.00	06500	RESPIRATORY THERAPY	0	486	0	4,612	187,064	65.00
66.00	06600	PHYSICAL THERAPY	0	349	0	838	96,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	160	0	0	40,447	67.00
68.00	06800	SPEECH PATHOLOGY	0	70	0	838	22,167	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	11,862	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	216	0	0	113,589	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	60,358	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	12,273	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	8,347	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	413	1,846	19,077	237,675	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	221	0	0	71,594	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	1,916	90.03
91.00	09100	EMERGENCY	0	682	3,048	18,027	345,296	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	203,713	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	38,845	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	212,997	7,114	16,607	67,079	3,678,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	57,310	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	12,162	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	212,997	7,114	16,607	67,079	3,747,520	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			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
5.01	00540	ADMINISTRATIVE AND GENERAL				5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER				5.02
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,045,848		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	30,623		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	557,150		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	132,892		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	302,413		54.00
60.00	06000	LABORATORY	0	154,054		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,148		62.00
65.00	06500	RESPIRATORY THERAPY	0	187,064		65.00
66.00	06600	PHYSICAL THERAPY	0	96,195		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40,447		67.00
68.00	06800	SPEECH PATHOLOGY	0	22,167		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,862		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,579		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	113,589		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	60,358		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	12,273		88.01
88.02	08803	RURAL HEALTH CLINIC III	0	8,347		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	0	237,675		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
90.02	09002	WOUND CARE	0	71,594		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	1,916		90.03
91.00	09100	EMERGENCY	0	345,296		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	203,713		95.00
101.00	10100	HOME HEALTH AGENCY	0	38,845		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,678,048		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57,310		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,162		192.00
192.01	19201	MARKETING	0	0		192.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,747,520		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	122,517					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		122,517				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	578	578	12,969,986			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	9,350	9,350	980,586	-2,949,213	34,106,390	5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	7,726	7,726	1,121,507	0	3,718,434	5.02
7.00	00700	OPERATION OF PLANT	23,439	23,439	257,042	0	2,388,082	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200	200	0	0	87,039	8.00
9.00	00900	HOUSEKEEPING	1,345	1,345	270,945	0	466,971	9.00
10.00	01000	DIETARY	5,102	5,102	0	0	296,818	10.00
11.00	01100	CAFETERIA	0	0	0	0	402,358	11.00
13.00	01300	NURSING ADMINISTRATION	270	270	237,542	0	298,108	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,500	1,500	171,072	0	313,289	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,772	17,772	1,898,829	0	4,255,959	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	726	726	29,396	0	57,830	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,063	13,063	615,839	0	1,182,745	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,205	3,205	28,676	0	132,785	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,612	6,612	810,127	0	1,521,061	54.00
60.00	06000	LABORATORY	2,732	2,732	720,295	0	2,125,065	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1,435	0	64,810	62.00
65.00	06500	RESPIRATORY THERAPY	4,108	4,108	471,715	0	790,585	65.00
66.00	06600	PHYSICAL THERAPY	2,020	2,020	417,470	0	677,777	66.00
67.00	06700	OCCUPATIONAL THERAPY	877	877	159,939	0	246,452	67.00
68.00	06800	SPEECH PATHOLOGY	461	461	89,264	0	133,820	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	670,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	145,869	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,507	1,507	77,456	0	2,935,591	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,881,538	0	3,268,683	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	346,091	0	667,446	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	160,380	0	459,738	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	5,008	5,008	311,851	0	658,491	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	1,582	1,582	294,582	0	370,698	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	79,731	0	102,226	90.03
91.00	09100	EMERGENCY	6,857	6,857	684,936	0	2,318,475	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,500	4,500	0	0	1,157,184	95.00
101.00	10100	HOME HEALTH AGENCY	588	588	0	0	842,857	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	121,128	121,128	12,118,244	-2,949,213	32,758,145	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,389	1,389	0	0	42,486	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	851,742	0	1,305,759	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,612,383	1,135,137	2,747,707		2,949,213	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.322616	9.265139	0.211851		0.086471	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,679		287,332	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001363		0.008425	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL - OTHER (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	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
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER	-4,039,971	31,596,963				5.02
7.00	00700	OPERATION OF PLANT	0	2,594,582	81,424			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	94,565	200	10,127		8.00
9.00	00900	HOUSEKEEPING	0	507,350	1,345	1,990	79,879	9.00
10.00	01000	DIETARY	0	322,484	5,102	0	5,102	10.00
11.00	01100	CAFETERIA	0	437,150	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	323,886	270	0	270	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	340,379	1,500	0	1,500	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,623,976	17,772	2,756	17,772	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	62,831	726	0	726	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,285,018	13,063	1,001	13,063	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	144,267	3,205	0	3,205	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,652,589	6,612	1,101	6,612	54.00
60.00	06000	LABORATORY	0	2,308,821	2,732	45	2,732	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	70,414	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	858,948	4,108	76	4,108	65.00
66.00	06600	PHYSICAL THERAPY	0	736,385	2,020	216	2,020	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	267,763	877	0	877	67.00
68.00	06800	SPEECH PATHOLOGY	0	145,392	461	0	461	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	728,912	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	158,482	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,189,434	1,507	0	1,507	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,551,329	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	725,161	0	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	499,492	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	715,431	5,008	371	5,008	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	402,753	1,582	0	1,582	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	111,066	0	0	0	90.03
91.00	09100	EMERGENCY	0	2,518,956	6,857	2,553	6,857	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,257,247	4,500	18	4,500	95.00
101.00	10100	HOME HEALTH AGENCY	0	915,740	588	0	588	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,039,971	31,550,803	80,035	10,127	78,490	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,160	1,389	0	1,389	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-1,418,669	0	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)		4,039,971	2,926,323	113,844	642,928	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.127859	35.939318	11.241631	8.048774	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		269,178	759,519	9,523	64,183	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.008519	9.327950	0.940357	0.803503	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 6/8/2020 8:34 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			10.00	11.00	13.00	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
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	ADMINISTRATIVE AND GENERAL - OTHER						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	6,865					10.00
11.00	01100	CAFETERIA	0	12,143				11.00
13.00	01300	NURSING ADMINISTRATION	0	29	131,937			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	389	0	320		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,865	3,680	76,548	81		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0		31.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	794	16,511	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,352	0	16		54.00
60.00	06000	LABORATORY	0	1,466	0	16		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	830	0	22		65.00
66.00	06600	PHYSICAL THERAPY	0	595	0	4		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	273	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	120	0	4		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	368	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
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0		88.03
90.00	09000	CLINIC	0	705	14,664	91		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0		90.01
90.02	09002	WOUND CARE	0	378	0	0		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	0	1,164	24,214	86		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
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,865	12,143	131,937	320		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	MARKETING	0	0	0	0		192.01
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)	588,143	493,044	378,352	465,677		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	85.672688	40.603146	2.867672	1,455.240625		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	212,997	7,114	16,607	67,079		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	31.026511	0.585852	0.125871	209.621875		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,102,898		7,102,898	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	102,800		102,800	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,114,775		2,114,775	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	303,695		303,695	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,245,292		2,245,292	0	0	54.00
60.00	06000	LABORATORY	2,807,514		2,807,514	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,417		79,417	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,216,045	0	1,216,045	0	0	65.00
66.00	06600	PHYSICAL THERAPY	951,802	0	951,802	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	351,662	0	351,662	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	194,953	0	194,953	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	822,110		822,110	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	178,745		178,745	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,678,465		3,678,465	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,005,398		4,005,398	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	817,879		817,879	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	563,357		563,357	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
90.00	09000	CLINIC	1,234,472		1,234,472	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	539,186		539,186	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	125,267		125,267	0	0	90.03
91.00	09100	EMERGENCY	3,413,204		3,413,204	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,301,124		1,301,124		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,616,145		1,616,145	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,058,691		1,058,691		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	36,824,896	0	36,824,896	0	0	200.00
201.00		Less Observation Beds	1,301,124		1,301,124		0	201.00
202.00		Total (see instructions)	35,523,772	0	35,523,772	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,496,069		2,496,069			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	87,714		87,714			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	836,126	6,808,298	7,644,424	0.276643	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	309,828	161,843	471,671	0.643870	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,040,896	20,504,009	21,544,905	0.104215	0.000000	54.00
60.00	06000	LABORATORY	1,427,128	15,184,749	16,611,877	0.169006	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	41,546	237,837	279,383	0.284259	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	980,223	2,631,528	3,611,751	0.336691	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	453,290	2,247,150	2,700,440	0.352462	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,841	796,498	1,177,339	0.298692	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	82,656	417,836	500,492	0.389523	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,327,683	3,109,657	4,437,340	0.185271	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	932	181,404	182,336	0.980306	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,461,219	14,245,347	16,706,566	0.220181	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,532,703	3,532,703			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,143,331	1,143,331			88.01
88.02	08803	RURAL HEALTH CLINIC III	0	537,405	537,405			88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0			88.03
90.00	09000	CLINIC	221,703	1,147,872	1,369,575	0.901354	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	20,700	1,987,960	2,008,660	0.268431	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	475,009	475,009	0.263715	0.000000	90.03
91.00	09100	EMERGENCY	282,214	7,499,527	7,781,741	0.438617	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	57,685	654,082	711,767	1.828020	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,858,719	3,858,719	0.418829	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	3,005,345	3,005,345			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	12,508,453	90,368,109	102,876,562			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,508,453	90,368,109	102,876,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 8:34 am

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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
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			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
88.02	08803	RURAL HEALTH CLINIC III			88.02
88.03	08802	RURAL HEALTH CLINIC IV			88.03
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PAIN MANAGEMENT	0.000000		90.01
90.02	09002	WOUND CARE	0.000000		90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,102,898		7,102,898	0	7,102,898	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	102,800		102,800	0	102,800	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,114,775		2,114,775	0	2,114,775	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	303,695		303,695	0	303,695	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,245,292		2,245,292	0	2,245,292	54.00
60.00	06000	LABORATORY	2,807,514		2,807,514	0	2,807,514	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,417		79,417	0	79,417	62.00
65.00	06500	RESPIRATORY THERAPY	1,216,045	0	1,216,045	0	1,216,045	65.00
66.00	06600	PHYSICAL THERAPY	951,802	0	951,802	0	951,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	351,662	0	351,662	0	351,662	67.00
68.00	06800	SPEECH PATHOLOGY	194,953	0	194,953	0	194,953	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	822,110		822,110	0	822,110	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	178,745		178,745	0	178,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,678,465		3,678,465	0	3,678,465	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,005,398		4,005,398	0	4,005,398	88.00
88.01	08801	RURAL HEALTH CLINIC II	817,879		817,879	0	817,879	88.01
88.02	08803	RURAL HEALTH CLINIC III	563,357		563,357	0	563,357	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0		0	0	0	88.03
90.00	09000	CLINIC	1,234,472		1,234,472	0	1,234,472	90.00
90.01	09001	PAIN MANAGEMENT	0		0	0	0	90.01
90.02	09002	WOUND CARE	539,186		539,186	0	539,186	90.02
90.03	09003	ORTHOPEDIC CLINIC	125,267		125,267	0	125,267	90.03
91.00	09100	EMERGENCY	3,413,204		3,413,204	0	3,413,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,301,124		1,301,124		1,301,124	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,616,145		1,616,145	0	1,616,145	95.00
101.00	10100	HOME HEALTH AGENCY	1,058,691		1,058,691		1,058,691	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	36,824,896	0	36,824,896	0	36,824,896	200.00
201.00		Less Observation Beds	1,301,124		1,301,124		1,301,124	201.00
202.00		Total (see instructions)	35,523,772	0	35,523,772	0	35,523,772	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,496,069		2,496,069			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	87,714		87,714			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	836,126	6,808,298	7,644,424	0.276643	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	309,828	161,843	471,671	0.643870	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,040,896	20,504,009	21,544,905	0.104215	0.000000	54.00
60.00	06000	LABORATORY	1,427,128	15,184,749	16,611,877	0.169006	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	41,546	237,837	279,383	0.284259	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	980,223	2,631,528	3,611,751	0.336691	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	453,290	2,247,150	2,700,440	0.352462	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,841	796,498	1,177,339	0.298692	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	82,656	417,836	500,492	0.389523	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,327,683	3,109,657	4,437,340	0.185271	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	932	181,404	182,336	0.980306	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,461,219	14,245,347	16,706,566	0.220181	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,532,703	3,532,703	1.133805	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,143,331	1,143,331	0.715348	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	537,405	537,405	1.048291	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0.000000	0.000000	88.03
90.00	09000	CLINIC	221,703	1,147,872	1,369,575	0.901354	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CARE	20,700	1,987,960	2,008,660	0.268431	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	475,009	475,009	0.263715	0.000000	90.03
91.00	09100	EMERGENCY	282,214	7,499,527	7,781,741	0.438617	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	57,685	654,082	711,767	1.828020	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,858,719	3,858,719	0.418829	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	3,005,345	3,005,345			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	12,508,453	90,368,109	102,876,562			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,508,453	90,368,109	102,876,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		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
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.276643		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.643870		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104215		54.00
60.00	06000	LABORATORY	0.169006		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.284259		62.00
65.00	06500	RESPIRATORY THERAPY	0.336691		65.00
66.00	06600	PHYSICAL THERAPY	0.352462		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298692		67.00
68.00	06800	SPEECH PATHOLOGY	0.389523		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.185271		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.980306		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220181		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.133805		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.715348		88.01
88.02	08803	RURAL HEALTH CLINIC III	1.048291		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000		88.03
90.00	09000	CLINIC	0.901354		90.00
90.01	09001	PAIN MANAGEMENT	0.000000		90.01
90.02	09002	WOUND CARE	0.268431		90.02
90.03	09003	ORTHOPEDIC CLINIC	0.263715		90.03
91.00	09100	EMERGENCY	0.438617		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.828020		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.418829		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,114,775	557,150	1,557,625	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	303,695	132,892	170,803	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,245,292	302,413	1,942,879	0	0	54.00
60.00	06000	LABORATORY	2,807,514	154,054	2,653,460	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,417	1,148	78,269	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,216,045	187,064	1,028,981	0	0	65.00
66.00	06600	PHYSICAL THERAPY	951,802	96,195	855,607	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	351,662	40,447	311,215	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	194,953	22,167	172,786	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	822,110	11,862	810,248	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	178,745	2,579	176,166	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,678,465	113,589	3,564,876	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,005,398	60,358	3,945,040	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	817,879	12,273	805,606	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	563,357	8,347	555,010	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	1,234,472	237,675	996,797	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	539,186	71,594	467,592	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	125,267	1,916	123,351	0	0	90.03
91.00	09100	EMERGENCY	3,413,204	345,296	3,067,908	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,301,124	191,580	1,109,544	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,616,145	203,713	1,412,432	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,058,691	38,845	1,019,846	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	29,619,198	2,793,157	26,826,041	0	0	200.00
201.00		Less Observation Beds	1,301,124	191,580	1,109,544	0	0	201.00
202.00		Total (line 200 minus line 201)	28,318,074	2,601,577	25,716,497	0	0	202.00

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

Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part II Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,114,775	7,644,424	0.276643		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	303,695	471,671	0.643870		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,245,292	21,544,905	0.104215		54.00
60.00	06000	LABORATORY	2,807,514	16,611,877	0.169006		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	79,417	279,383	0.284259		62.00
65.00	06500	RESPIRATORY THERAPY	1,216,045	3,611,751	0.336691		65.00
66.00	06600	PHYSICAL THERAPY	951,802	2,700,440	0.352462		66.00
67.00	06700	OCCUPATIONAL THERAPY	351,662	1,177,339	0.298692		67.00
68.00	06800	SPEECH PATHOLOGY	194,953	500,492	0.389523		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	822,110	4,437,340	0.185271		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	178,745	182,336	0.980306		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,678,465	16,706,566	0.220181		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,005,398	3,532,703	1.133805		88.00
88.01	08801	RURAL HEALTH CLINIC II	817,879	1,143,331	0.715348		88.01
88.02	08803	RURAL HEALTH CLINIC III	563,357	537,405	1.048291		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0.000000		88.03
90.00	09000	CLINIC	1,234,472	1,369,575	0.901354		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000		90.01
90.02	09002	WOUND CARE	539,186	2,008,660	0.268431		90.02
90.03	09003	ORTHOPEDIC CLINIC	125,267	475,009	0.263715		90.03
91.00	09100	EMERGENCY	3,413,204	7,781,741	0.438617		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,301,124	711,767	1.828020		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,616,145	3,858,719	0.418829		95.00
101.00	10100	HOME HEALTH AGENCY	1,058,691	3,005,345	0.352269		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	29,619,198	100,292,779			200.00
201.00		Less Observation Beds	1,301,124	0			201.00
202.00		Total (line 200 minus line 201)	28,318,074	100,292,779			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	557,150	7,644,424	0.072883	167,498	12,208	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	132,892	471,671	0.281747	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	302,413	21,544,905	0.014036	477,114	6,697	54.00
60.00	06000	LABORATORY	154,054	16,611,877	0.009274	549,212	5,093	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,148	279,383	0.004109	12,241	50	62.00
65.00	06500	RESPIRATORY THERAPY	187,064	3,611,751	0.051793	412,542	21,367	65.00
66.00	06600	PHYSICAL THERAPY	96,195	2,700,440	0.035622	135,878	4,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,447	1,177,339	0.034355	99,195	3,408	67.00
68.00	06800	SPEECH PATHOLOGY	22,167	500,492	0.044290	41,469	1,837	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,862	4,437,340	0.002673	441,070	1,179	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,579	182,336	0.014144	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,589	16,706,566	0.006799	1,157,664	7,871	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	60,358	3,532,703	0.017086	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,273	1,143,331	0.010734	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	8,347	537,405	0.015532	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
90.00	09000	CLINIC	237,675	1,369,575	0.173539	97,719	16,958	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	71,594	2,008,660	0.035643	8,028	286	90.02
90.03	09003	ORTHOPEDIC CLINIC	1,916	475,009	0.004034	0	0	90.03
91.00	09100	EMERGENCY	345,296	7,781,741	0.044373	33,439	1,484	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	191,580	711,767	0.269161	4,410	1,187	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,550,599	93,428,715		3,637,479	84,465	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,644,424	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	471,671	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,544,905	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,611,877	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	279,383	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,611,751	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,700,440	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,177,339	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	500,492	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,437,340	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	182,336	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,706,566	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,532,703	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,143,331	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	537,405	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
90.00	09000	CLINIC	0	0	0	1,369,575	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	2,008,660	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	475,009	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	7,781,741	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	711,767	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	93,428,715		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		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	167,498	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	477,114	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	549,212	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	12,241	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	412,542	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	135,878	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	99,195	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	41,469	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	441,070	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,157,664	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	97,719	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	8,028	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	33,439	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,410	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		3,637,479	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.276643	0	1,955,022	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.643870	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104215	0	6,740,985	0	0	54.00
60.00	06000	LABORATORY	0.169006	0	3,232,349	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.284259	0	118,821	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.336691	0	865,126	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.352462	0	918,191	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298692	0	205,313	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.389523	0	42,639	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.185271	0	904,594	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.980306	0	115,818	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220181	0	7,751,601	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000				0	88.03
90.00	09000	CLINIC	0.901354	0	458,551	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.268431	0	1,214,865	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.263715	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.438617	0	2,050,405	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.828020	0	284,084	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.418829		0			95.00
200.00		Subtotal (see instructions)		0	26,858,364	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	26,858,364	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	540,843	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	702,512	0		54.00
60.00	06000	LABORATORY	546,286	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,776	0		62.00
65.00	06500	RESPIRATORY THERAPY	291,280	0		65.00
66.00	06600	PHYSICAL THERAPY	323,627	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	61,325	0		67.00
68.00	06800	SPEECH PATHOLOGY	16,609	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	167,595	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	113,537	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,706,755	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
88.02	08803	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	413,317	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
90.02	09002	WOUND CARE	326,107	0		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0		90.03
91.00	09100	EMERGENCY	899,342	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	519,311	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,662,222	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,662,222	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.276643	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.643870	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104215	0	0	0	0	54.00
60.00	06000	LABORATORY	0.169006	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.284259	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.336691	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.352462	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298692	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.389523	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.185271	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.980306	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220181	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000				0	88.03
90.00	09000	CLINIC	0.901354	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.268431	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.263715	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.438617	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.828020	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.418829		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: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
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
88.02	08803	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
90.02	09002	WOUND CARE	0	0		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part I Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,045,848	258,921	786,927	2,177	361.47	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
43.00	NURSERY	30,623		30,623	99	309.32	43.00
200.00	Total (lines 30 through 199)	1,076,471		817,550	2,276		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	60	21,688		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	8	2,475		43.00
200.00	Total (lines 30 through 199)	68	24,163		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	557,150	7,644,424	0.072883	281,610	20,525	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	132,892	471,671	0.281747	133,376	37,578	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	302,413	21,544,905	0.014036	112,428	1,578	54.00
60.00	06000	LABORATORY	154,054	16,611,877	0.009274	149,473	1,386	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,148	279,383	0.004109	125	1	62.00
65.00	06500	RESPIRATORY THERAPY	187,064	3,611,751	0.051793	46,828	2,425	65.00
66.00	06600	PHYSICAL THERAPY	96,195	2,700,440	0.035622	5,285	188	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,447	1,177,339	0.034355	2,094	72	67.00
68.00	06800	SPEECH PATHOLOGY	22,167	500,492	0.044290	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,862	4,437,340	0.002673	214,831	574	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,579	182,336	0.014144	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	113,589	16,706,566	0.006799	218,763	1,487	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	60,358	3,532,703	0.017086	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,273	1,143,331	0.010734	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	8,347	537,405	0.015532	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0.000000	0	0	88.03
90.00	09000	CLINIC	237,675	1,369,575	0.173539	36,599	6,351	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CARE	71,594	2,008,660	0.035643	8,549	305	90.02
90.03	09003	ORTHOPEDIC CLINIC	1,916	475,009	0.004034	0	0	90.03
91.00	09100	EMERGENCY	345,296	7,781,741	0.044373	65,489	2,906	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	191,580	711,767	0.269161	19,066	5,132	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	2,550,599	93,428,715		1,294,516	80,508	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part III Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	2,177	0.00	60	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0.00	0	31.00
43.00	04300	NURSERY		0	99	0.00	8	43.00
200.00		Total (lines 30 through 199)		0	2,276		68	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
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
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
90.02	09002	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						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: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	7,644,424	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	471,671	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,544,905	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	16,611,877	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	279,383	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,611,751	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,700,440	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,177,339	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	500,492	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4,437,340	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	182,336	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	16,706,566	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,532,703	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,143,331	0.000000	88.01
88.02	08803	RURAL HEALTH CLINIC III	0	0	0	537,405	0.000000	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0	0	0	0.000000	88.03
90.00	09000	CLINIC	0	0	0	1,369,575	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0.000000	90.01
90.02	09002	WOUND CARE	0	0	0	2,008,660	0.000000	90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0	0	475,009	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	7,781,741	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	711,767	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	93,428,715		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | 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	281,610	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	133,376	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	112,428	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	149,473	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	125	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	46,828	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,285	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,094	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	214,831	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	218,763	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000	0	0	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000	0	0	0	0	88.03
90.00	09000	CLINIC	0.000000	36,599	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.000000	8,549	0	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	65,489	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	19,066	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		1,294,516	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.276643	0	815,278	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.643870	0	21,167	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104215	0	2,291,076	0	0	54.00
60.00	06000	LABORATORY	0.169006	0	1,636,181	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.284259	0	18,675	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.336691	0	215,896	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.352462	0	198,309	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298692	0	95,867	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.389523	0	46,858	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.185271	0	437,696	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.980306	0	5,302	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220181	0	721,493	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.133805				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.715348				0	88.01
88.02	08803	RURAL HEALTH CLINIC III	1.048291				0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000				0	88.03
90.00	09000	CLINIC	0.901354	0	112,469	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CARE	0.268431	0	122,857	0	0	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.263715	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.438617	0	1,135,843	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.828020	0	80,000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.418829	0	81,448			95.00
200.00		Subtotal (see instructions)		0	8,036,415	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	8,036,415	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	225,541	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,629	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	238,764	0		54.00
60.00	06000	LABORATORY	276,524	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,309	0		62.00
65.00	06500	RESPIRATORY THERAPY	72,690	0		65.00
66.00	06600	PHYSICAL THERAPY	69,896	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,635	0		67.00
68.00	06800	SPEECH PATHOLOGY	18,252	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	81,092	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,198	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	158,859	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
88.02	08803	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08802	RURAL HEALTH CLINIC IV	0	0		88.03
90.00	09000	CLINIC	101,374	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
90.02	09002	WOUND CARE	32,979	0		90.02
90.03	09003	ORTHOPEDIC CLINIC	0	0		90.03
91.00	09100	EMERGENCY	498,200	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	146,242	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	34,113			95.00
200.00		Subtotal (see instructions)	2,007,297	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,007,297	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,046	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,177	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)	1,647	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	706	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	163	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)	932	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)	706	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	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,102,898	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)	25,268	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)	1,758,463	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,344,435	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)	5,344,435	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)	2,454.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,288,013	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,288,013	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 8:34 am

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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)	874,508	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,162,521	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)	1,733,195	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)	1,733,195	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)	530	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,454.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,301,124	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,045,848	7,102,898	0.147242	1,301,124	191,580	90.00
91.00	Nursing School cost	0	7,102,898	0.000000	1,301,124	0	91.00
92.00	Allied health cost	0	7,102,898	0.000000	1,301,124	0	92.00
93.00	All other Medical Education	0	7,102,898	0.000000	1,301,124	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | 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)	3,046	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,177	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)	1,647	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	706	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	163	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)	60	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)	706	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	163	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)	99	15.00
16.00	Nursery days (title V or XIX only)	8	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	155.02	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	155.02	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,102,898	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)	25,268	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)	1,758,463	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,344,435	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)	5,344,435	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)	2,454.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	147,297	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)	147,297	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	102,800	99	1,038.38	8	8,307	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)	405,883	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	561,487	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)	24,163	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	80,508	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	104,671	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	456,816	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)	1,733,195	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)	1,733,195	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)	25,268	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)	25,268	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)	530	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,454.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,301,124	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | 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	1,045,848	7,102,898	0.147242	1,301,124	191,580	90.00
91.00	Nursing School cost	0	7,102,898	0.000000	1,301,124	0	91.00
92.00	Allied health cost	0	7,102,898	0.000000	1,301,124	0	92.00
93.00	All other Medical Education	0	7,102,898	0.000000	1,301,124	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 8:34 am

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		1,279,733		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.276643	167,498	46,337	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.643870	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104215	477,114	49,722	54.00
60.00	06000	LABORATORY	0.169006	549,212	92,820	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.284259	12,241	3,480	62.00
65.00	06500	RESPIRATORY THERAPY	0.336691	412,542	138,899	65.00
66.00	06600	PHYSICAL THERAPY	0.352462	135,878	47,892	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298692	99,195	29,629	67.00
68.00	06800	SPEECH PATHOLOGY	0.389523	41,469	16,153	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.185271	441,070	81,717	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.980306	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220181	1,157,664	254,896	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.901354	97,719	88,079	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.268431	8,028	2,155	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.263715	0	0	90.03
91.00	09100	EMERGENCY	0.438617	33,439	14,667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.828020	4,410	8,062	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)		3,637,479	874,508	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)		3,637,479		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 8:34 am

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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.276643	2,892	800	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.643870	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104215	24,443	2,547	54.00
60.00	06000	LABORATORY	0.169006	141,399	23,897	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.284259	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.336691	145,690	49,053	65.00
66.00	06600	PHYSICAL THERAPY	0.352462	216,631	76,354	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298692	198,004	59,142	67.00
68.00	06800	SPEECH PATHOLOGY	0.389523	30,127	11,735	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.185271	134,427	24,905	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.980306	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220181	276,042	60,779	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
88.02	08803	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000		0	88.03
90.00	09000	CLINIC	0.901354	6,977	6,289	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.268431	2,035	546	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.263715	0	0	90.03
91.00	09100	EMERGENCY	0.438617	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.828020	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,178,667	316,047	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)		1,178,667		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 6/8/2020 8:34 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		192,134		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		7,088		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.276643	281,610	77,905	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.643870	133,376	85,877	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104215	112,428	11,717	54.00
60.00	06000	LABORATORY	0.169006	149,473	25,262	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.284259	125	36	62.00
65.00	06500	RESPIRATORY THERAPY	0.336691	46,828	15,767	65.00
66.00	06600	PHYSICAL THERAPY	0.352462	5,285	1,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.298692	2,094	625	67.00
68.00	06800	SPEECH PATHOLOGY	0.389523	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.185271	214,831	39,802	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.980306	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220181	218,763	48,167	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.133805	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.715348	0	0	88.01
88.02	08803	RURAL HEALTH CLINIC III	1.048291	0	0	88.02
88.03	08802	RURAL HEALTH CLINIC IV	0.000000	0	0	88.03
90.00	09000	CLINIC	0.901354	36,599	32,989	90.00
90.01	09001	PAIN MANAGEMENT	0.000000	0	0	90.01
90.02	09002	WOUND CARE	0.268431	8,549	2,295	90.02
90.03	09003	ORTHOPEDIC CLINIC	0.263715	0	0	90.03
91.00	09100	EMERGENCY	0.438617	65,489	28,725	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.828020	19,066	34,853	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)		1,294,516	405,883	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)		1,294,516		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/8/2020 8:34 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,662,222	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)	6,662,222	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,728,844	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)	45,414	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,684,493	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)	1,998,937	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)	1,998,937	30.00
31.00	Primary payer payments	751	31.00
32.00	Subtotal (line 30 minus line 31)	1,998,186	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	1,018,257	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	661,867	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	442,695	36.00
37.00	Subtotal (see instructions)	2,660,053	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,660,053	40.00
40.01	Sequestration adjustment (see instructions)	53,201	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,023,937	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-417,085	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,291,269		3,023,937	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,291,269		3,023,937	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		597,602		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		417,085	6.02
7.00	Total Medicare program liability (see instructions)		2,888,871		2,606,852	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: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,376,681		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,376,681		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		651,658		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,028,339		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: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 6/8/2020 8:34 am
	Title XVIII	Hospital	Cost

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1322 | Component CCN: 15-Z322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,750,527	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	319,207	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	706	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)	2,069,734	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,069,734	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)	2,069,734	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,069,734	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)	2,069,734	0	19.00
19.01	Sequestration adjustment (see instructions)	41,395	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	1,376,681	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	651,658	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision 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: 15-1322	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 6/8/2020 8:34 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,162,521	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)	3,162,521	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,194,146	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)	3,194,146	19.00
20.00	Deductibles (exclude professional component)	305,536	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,888,610	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,888,610	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	91,104	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	59,218	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	10,576	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,947,828	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)	2,947,828	30.00
30.01	Sequestration adjustment (see instructions)	58,957	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,291,269	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	597,602	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 6/8/2020 8:34 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,949,639	0	0	0	1.00
2.00	Temporary investments	3,893,530	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,980,212	0	0	0	4.00
5.00	Other receivable	705,366	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,246,687	0	0	0	6.00
7.00	Inventory	899,185	0	0	0	7.00
8.00	Prepaid expenses	465,064	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,820,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,466,309	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,815,753	0	0	0	12.00
13.00	Land improvements	66,330	0	0	0	13.00
14.00	Accumulated depreciation	-9,226,705	0	0	0	14.00
15.00	Buildings	44,023,461	0	0	0	15.00
16.00	Accumulated depreciation	-2,599,994	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	2,330,717	0	0	0	19.00
20.00	Accumulated depreciation	-166,739	0	0	0	20.00
21.00	Automobiles and trucks	477,834	0	0	0	21.00
22.00	Accumulated depreciation	-310,122	0	0	0	22.00
23.00	Major movable equipment	16,244,053	0	0	0	23.00
24.00	Accumulated depreciation	-9,064,914	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	45,589,674	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,055,983	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,232,473	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	404,436	0	0	0	39.00
40.00	Notes and loans payable (short term)	641,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,451,736	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,729,645	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	36,693,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	36,693,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	41,422,645	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,633,338				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)	22,633,338	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,055,983	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 6/8/2020 8:34 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		21,036,395		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,596,943				2.00
3.00	Total (sum of line 1 and line 2)		22,633,338		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)		22,633,338		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)		22,633,338		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: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/8/2020 8:34 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,342,485		2,342,485	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,342,485		2,342,485	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	246,260		246,260	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)	246,260		246,260	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,588,745		2,588,745	17.00
18.00	Ancillary services	9,890,564	79,903,532	89,794,096	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	3,532,703	3,532,703	20.00
20.01	RURAL HEALTH CLINIC II	0	1,143,331	1,143,331	20.01
20.02	RURAL HEALTH CLINIC III	0	537,405	537,405	20.02
20.03	RURAL HEALTH CLINIC IV	0	-116	-116	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		3,005,345	3,005,345	22.00
23.00	AMBULANCE SERVICES	0	3,858,719	3,858,719	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,479,309	91,980,919	104,460,228	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		40,075,912		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)		40,075,912		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1322 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 6/8/2020 8:34 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	104,460,228	1.00
2.00	Less contractual allowances and discounts on patients' accounts	66,295,416	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,164,812	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	40,075,912	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,911,100	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	306,883	6.00
7.00	Income from investments	101,885	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	55,155	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	104,718	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	0	21.00
22.00	Rental of hospital space	89,559	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	2,849,843	24.00
25.00	Total other income (sum of lines 6-24)	3,508,043	25.00
26.00	Total (line 5 plus line 25)	1,596,943	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)	1,596,943	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H | Date/Time Prepared: 6/8/2020 8:34 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	106,631	81,373	0	7,200	92,020	287,224	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	214,804	0	0	0	0	214,804	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	251,426	0	0	0	0	251,426	10.00
11.00	Home Health Aide	56,719	0	0	0	0	56,719	11.00
12.00	Supplies (see instructions)	0	0	0	0	12,232	12,232	12.00
13.00	Drugs	0	0	0	0	265	265	13.00
14.00	DME	0	0	0	0	2,201	2,201	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	629,580	81,373	0	7,200	106,718	824,871	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-31,373	255,851	0	255,851			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	214,804	0	214,804			6.00
7.00	Physical Therapy	161,586	161,586	0	161,586			7.00
8.00	Occupational Therapy	104,303	104,303	0	104,303			8.00
9.00	Speech Pathology	16,628	16,628	0	16,628			9.00
10.00	Medical Social Services	-251,144	282	0	282			10.00
11.00	Home Health Aide	0	56,719	0	56,719			11.00
12.00	Supplies (see instructions)	0	12,232	0	12,232			12.00
13.00	Drugs	0	265	0	265			13.00
14.00	DME	0	2,201	0	2,201			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	824,871	0	824,871			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-1 Part I | Date/Time Prepared: 6/8/2020 8:34 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	255,851	0	0	0	0	255,851	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	214,804	0	0	0	0	214,804	6.00
7.00	Physical Therapy	161,586	0	0	0	0	161,586	7.00
8.00	Occupational Therapy	104,303	0	0	0	0	104,303	8.00
9.00	Speech Pathology	16,628	0	0	0	0	16,628	9.00
10.00	Medical Social Services	282	0	0	0	0	282	10.00
11.00	Home Health Aide	56,719	0	0	0	0	56,719	11.00
12.00	Supplies (see instructions)	12,232	0	0	0	0	12,232	12.00
13.00	Drugs	265	0	0	0		265	13.00
14.00	DME	2,201	0	0	0	0	2,201	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	824,871	0	0	0	0	824,871	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	255,851		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	96,582	311,386	6.00
7.00	Physical Therapy	72,655	234,241	7.00
8.00	Occupational Therapy	46,898	151,201	8.00
9.00	Speech Pathology	7,477	24,105	9.00
10.00	Medical Social Services	127	409	10.00
11.00	Home Health Aide	25,503	82,222	11.00
12.00	Supplies (see instructions)	5,500	17,732	12.00
13.00	Drugs	119	384	13.00
14.00	DME	990	3,191	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		824,871	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-1 Part II Date/Time Prepared: 6/8/2020 8:34 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	588				0		1.00
2.00	Capital Related - Movable Equipment		588			0		2.00
3.00	Plant Operation & Maintenance	0	0	588		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	588	588	588	0	-255,851	569,020	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	214,804	6.00
7.00	Physical Therapy	0	0	0	0	0	161,586	7.00
8.00	Occupational Therapy	0	0	0	0	0	104,303	8.00
9.00	Speech Pathology	0	0	0	0	0	16,628	9.00
10.00	Medical Social Services	0	0	0	0	0	282	10.00
11.00	Home Health Aide	0	0	0	0	0	56,719	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12,232	12.00
13.00	Drugs	0	0	0		0	265	13.00
14.00	DME	0	0	0	0	0	2,201	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	588	588	588	0	-255,851	569,020	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		255,851	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.449634	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part I | Date/Time Prepared: 6/8/2020 8:34 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	12,538	5,448	0	17,986	1,555	1.00
2.00	Skilled Nursing Care	311,386	0	0	0	311,386	26,927	2.00
3.00	Physical Therapy	234,241	0	0	0	234,241	20,255	3.00
4.00	Occupational Therapy	151,201	0	0	0	151,201	13,075	4.00
5.00	Speech Pathology	24,105	0	0	0	24,105	2,084	5.00
6.00	Medical Social Services	409	0	0	0	409	35	6.00
7.00	Home Health Aide	82,222	0	0	0	82,222	7,110	7.00
8.00	Supplies (see instructions)	17,732	0	0	0	17,732	1,533	8.00
9.00	Drugs	384	0	0	0	384	33	9.00
10.00	DME	3,191	0	0	0	3,191	276	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	824,871	12,538	5,448	0	842,857	72,883	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL - OTHER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5A.01	5.02	7.00	8.00	9.00	10.00	
1.00	Administrative and General	19,541	2,498	21,132	0	4,733	0	1.00
2.00	Skilled Nursing Care	338,313	43,258	0	0	0	0	2.00
3.00	Physical Therapy	254,496	32,540	0	0	0	0	3.00
4.00	Occupational Therapy	164,276	21,004	0	0	0	0	4.00
5.00	Speech Pathology	26,189	3,348	0	0	0	0	5.00
6.00	Medical Social Services	444	57	0	0	0	0	6.00
7.00	Home Health Aide	89,332	11,422	0	0	0	0	7.00
8.00	Supplies (see instructions)	19,265	2,463	0	0	0	0	8.00
9.00	Drugs	417	53	0	0	0	0	9.00
10.00	DME	3,467	443	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	915,740	117,086	21,132	0	4,733	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part I | Date/Time Prepared: 6/8/2020 8:34 am

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	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		11.00	13.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	47,904	0	47,904	1.00
2.00	Skilled Nursing Care	0	0	0	381,571	0	381,571	2.00
3.00	Physical Therapy	0	0	0	287,036	0	287,036	3.00
4.00	Occupational Therapy	0	0	0	185,280	0	185,280	4.00
5.00	Speech Pathology	0	0	0	29,537	0	29,537	5.00
6.00	Medical Social Services	0	0	0	501	0	501	6.00
7.00	Home Health Aide	0	0	0	100,754	0	100,754	7.00
8.00	Supplies (see instructions)	0	0	0	21,728	0	21,728	8.00
9.00	Drugs	0	0	0	470	0	470	9.00
10.00	DME	0	0	0	3,910	0	3,910	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	1,058,691	0	1,058,691	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	18,084	399,655					2.00
3.00	Physical Therapy	13,603	300,639					3.00
4.00	Occupational Therapy	8,781	194,061					4.00
5.00	Speech Pathology	1,400	30,937					5.00
6.00	Medical Social Services	24	525					6.00
7.00	Home Health Aide	4,775	105,529					7.00
8.00	Supplies (see instructions)	1,030	22,758					8.00
9.00	Drugs	22	492					9.00
10.00	DME	185	4,095					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Telemedicine	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	47,904	1,058,691					20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.047393						21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-2 Part II | Date/Time Prepared: 6/8/2020 8:34 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	
		1.00	2.00	4.00	5A.01	5.01	5A.02	
1.00	Administrative and General	588	588	0	0	17,986	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	311,386	0	2.00
3.00	Physical Therapy	0	0	0	0	234,241	0	3.00
4.00	Occupational Therapy	0	0	0	0	151,201	0	4.00
5.00	Speech Pathology	0	0	0	0	24,105	0	5.00
6.00	Medical Social Services	0	0	0	0	409	0	6.00
7.00	Home Health Aide	0	0	0	0	82,222	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	17,732	0	8.00
9.00	Drugs	0	0	0	0	384	0	9.00
10.00	DME	0	0	0	0	3,191	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	588	588	0		842,857		20.00
21.00	Total cost to be allocated	12,538	5,448	0		72,883		21.00
22.00	Unit cost multiplier	21.323129	9.265306	0.000000		0.086471		22.00

	Cost Center Description	ADMINISTRATIVE AND GENERAL - OTHER (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		5.02	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	19,541	588	0	588	0	0	1.00
2.00	Skilled Nursing Care	338,313	0	0	0	0	0	2.00
3.00	Physical Therapy	254,496	0	0	0	0	0	3.00
4.00	Occupational Therapy	164,276	0	0	0	0	0	4.00
5.00	Speech Pathology	26,189	0	0	0	0	0	5.00
6.00	Medical Social Services	444	0	0	0	0	0	6.00
7.00	Home Health Aide	89,332	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	19,265	0	0	0	0	0	8.00
9.00	Drugs	417	0	0	0	0	0	9.00
10.00	DME	3,467	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	915,740	588	0	588	0	0	20.00
21.00	Total cost to be allocated	117,086	21,132	0	4,733	0	0	21.00
22.00	Unit cost multiplier	0.127859	35.938776	0.000000	8.049320	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 15-1322
HHA CCN: 15-7177

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

Worksheet H-2 Part II
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	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)			
		13.00	16.00			
1.00	Administrative and General	0	0			1.00
2.00	Skilled Nursing Care	0	0			2.00
3.00	Physical Therapy	0	0			3.00
4.00	Occupational Therapy	0	0			4.00
5.00	Speech Pathology	0	0			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	0	0			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
19.50	Telemedicine	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0			20.00
21.00	Total cost to be allocated	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 15-1322 HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part I Date/Time Prepared: 6/8/2020 8:34 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	399,655		399,655	2,118	188.69	1.00
2.00	Physical Therapy	3.00	300,639	0	300,639	2,031	148.03	2.00
3.00	Occupational Therapy	4.00	194,061	0	194,061	1,311	148.03	3.00
4.00	Speech Pathology	5.00	30,937	0	30,937	209	148.02	4.00
5.00	Medical Social Services	6.00	525		525	4	131.25	5.00
6.00	Home Health Aide	7.00	105,529		105,529	865	122.00	6.00
7.00	Total (sum of lines 1-6)		1,031,346	0	1,031,346	6,538		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	1,041			8.00
9.00	Physical Therapy		99915	0	1,461			9.00
10.00	Occupational Therapy		99915	0	982			10.00
11.00	Speech Pathology		99915	0	176			11.00
12.00	Medical Social Services		99915	0	5			12.00
13.00	Home Health Aide		99915	0	218			13.00
14.00	Total (sum of lines 8-13)			0	3,883			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	22,758	0	22,758	0	0.000000	15.00
16.00	Cost of Drugs	9.00	492	0	492	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,041		0	196,426		1.00
2.00	Physical Therapy	0	1,461		0	216,272		2.00
3.00	Occupational Therapy	0	982		0	145,365		3.00
4.00	Speech Pathology	0	176		0	26,052		4.00
5.00	Medical Social Services	0	5		0	656		5.00
6.00	Home Health Aide	0	218		0	26,596		6.00
7.00	Total (sum of lines 1-6)	0	3,883		0	611,367		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1322 HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part I Date/Time Prepared: 6/8/2020 8:34 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	12,232	0	0	0	0	15.00
16.00	Cost of Drugs		265	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	196,426						1.00
2.00	Physical Therapy	216,272						2.00
3.00	Occupational Therapy	145,365						3.00
4.00	Speech Pathology	26,052						4.00
5.00	Medical Social Services	656						5.00
6.00	Home Health Aide	26,596						6.00
7.00	Total (sum of lines 1-6)	611,367						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-3 Part II | Date/Time Prepared: 6/8/2020 8:34 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.352462	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.298692	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.389523	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.185271	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.220181	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 15-1322 HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-4 Part I-II Date/Time Prepared: 6/8/2020 8:34 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	568,591	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	95,019	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	2,926	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	5,506	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	17,175	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	689,217	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	689,217	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	689,217	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	689,217	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	689,217	31.00
31.01	Sequestration adjustment (see instructions)	0	13,784	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	675,433	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 15-1322 | HHA CCN: 15-7177 | Period: From 01/01/2019 To 12/31/2019 | Worksheet H-5 | Date/Time Prepared: 6/8/2020 8:34 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		675,433	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		675,433	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		675,433	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 6/8/2020 8:34 am

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,069,934	0	1,069,934	5,529	1,075,463	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	207,163	0	207,163	0	207,163	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	266,725	0	266,725	0	266,725	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	169,292	0	169,292	0	169,292	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,713,114	0	1,713,114	5,529	1,718,643	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	7,068	7,068	0	7,068	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,068	7,068	0	7,068	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,713,114	7,068	1,720,182	5,529	1,725,711	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	53,913	53,913	0	53,913	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	53,913	53,913	0	53,913	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	152,444	942,609	1,095,053	5,769	1,100,822	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	152,444	942,609	1,095,053	5,769	1,100,822	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,865,558	1,003,590	2,869,148	11,298	2,880,446	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 6/8/2020 8:34 am

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,075,463		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	207,163		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	266,725		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	169,292		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,718,643		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	7,068		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	7,068		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,725,711		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	53,913		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	53,913		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-10,369	1,090,453		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-10,369	1,090,453		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-10,369	2,870,077		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 6/8/2020 8:34 am

RHC II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	258,578	0	258,578	-75,603	182,975	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	40,914	0	40,914	0	40,914	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	1,434	0	1,434	0	1,434	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	80,107	0	80,107	0	80,107	9.00
10.00	Subtotal (sum of lines 1 through 9)	381,033	0	381,033	-75,603	305,430	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	381,033	0	381,033	-75,603	305,430	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	87,568	87,568	0	87,568	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	87,568	87,568	0	87,568	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	48,789	152,339	201,128	0	201,128	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	48,789	152,339	201,128	0	201,128	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	429,822	239,907	669,729	-75,603	594,126	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 6/8/2020 8:34 am

RHC II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	182,975		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	40,914		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,434		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	80,107		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	305,430		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	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	305,430		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	87,568		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	87,568		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	201,128		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	201,128		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	594,126		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 6/8/2020 8:34 am

RHC III | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	195,181	195,181	0	195,181	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	99,187	0	99,187	-1,937	97,250	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	2,312	0	2,312	0	2,312	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	101,499	195,181	296,680	-1,937	294,743	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	211	211	0	211	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	211	211	0	211	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	101,499	195,392	296,891	-1,937	294,954	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	5,936	5,936	0	5,936	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	5,936	5,936	0	5,936	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	62,132	62,739	124,871	0	124,871	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	62,132	62,739	124,871	0	124,871	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	163,631	264,067	427,698	-1,937	425,761	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-1 | Date/Time Prepared: 6/8/2020 8:34 am

RHC III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	195,181		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	97,250		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	2,312		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	294,743		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	211		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	211		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	294,954		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	5,936		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	5,936		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	124,871		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	124,871		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	425,761		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8516 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 6/8/2020 8:34 am

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.32	8,860	4,200	5,544		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.68	6,351	2,100	3,528		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.00	15,211		9,072	15,211	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)	3.00	15,211			15,211	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,725,711	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					53,913	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,779,624	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.969705	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,090,453	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,135,321	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,225,774	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					2,225,774	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					2,158,344	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,884,055	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 6/8/2020 8:34 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC II Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.25	1,518	4,200	1,050		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.46	1,911	2,100	966		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.71	3,429		2,016	3,429	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)	0.71	3,429			3,429	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)					305,430	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					87,568	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					392,998	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.777180	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					201,128	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					223,753	15.00
16.00	Total overhead (sum of lines 14 and 15)					424,881	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					424,881	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					330,209	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					635,639	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-2 | Date/Time Prepared: 6/8/2020 8:34 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	RHC III Minimum Visits (col. 1 x col. 3)	Cost Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.09	279	4,200	378		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.60	2,455	2,100	1,260		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.69	2,734		1,638	2,734	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)	0.69	2,734			2,734	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)	294,954	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	5,936	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	300,890	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)	0.980272	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)	124,871	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	137,596	15.00
16.00	Total overhead (sum of lines 14 and 15)	262,467	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Enter the amount from line 16	262,467	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	257,289	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)	552,243	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 6/8/2020 8:34 am
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,884,055	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			125,735	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,758,320	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,211	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)			15,211	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			247.08	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)	247.08	247.08		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,402		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	840,566		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	840,566		16.00
16.01	Total program charges (see instructions)(from contractor's records)		908,121		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		81,769		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		75,686		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.)		556,052		16.04
16.05	Total program cost (see instructions)	0	631,738		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		69,815		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		151,302		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		631,738		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		56,156		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		687,894		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)		687,894		26.00
26.01	Sequestration adjustment (see instructions)		13,758		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		809,458		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)		-135,322		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: 15-1322 Component CCN: 15-8517	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 6/8/2020 8:34 am
	Title XVIII	RHC II	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			635,639	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			16,355	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			619,284	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,429	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,429	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			180.60	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)	180.60	180.60		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	167		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	30,160		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	30,160		16.00
16.01	Total program charges (see instructions)(from contractor's records)		42,388		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,589		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,554		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.)		18,109		16.04
16.05	Total program cost (see instructions)	0	20,663		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,970		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,766		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		20,663		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,404		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		22,067		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)		22,067		26.00
26.01	Sequestration adjustment (see instructions)		441		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		29,891		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		-8,265		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: 15-1322 Component CCN: 15-8518	Period: From 01/01/2019 To 12/31/2019	Worksheet M-3 Date/Time Prepared: 6/8/2020 8:34 am
	Title XVIII	RHC III	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			552,243	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			66,177	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			486,066	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			2,734	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			2,734	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			177.79	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)	177.79	177.79		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	515		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	91,562		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	91,562		16.00
16.01	Total program charges (see instructions)(from contractor's records)		94,447		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,040		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,978		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.)		63,343		16.04
16.05	Total program cost (see instructions)	0	65,321		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,405		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,401		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		65,321		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		50,567		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		115,888		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)		115,888		26.00
26.01	Sequestration adjustment (see instructions)		2,318		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		66,638		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)		46,932		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2019 To 12/31/2019	Worksheet M-4 Date/Time Prepared: 6/8/2020 8:34 am
	Title XVIII	RHC I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,718,643	1,718,643	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000855	0.016907	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,469	29,057	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,982	18,357	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	8,451	47,414	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,725,711	1,725,711	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	2,158,344	2,158,344	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004897	0.027475	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,569	59,301	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	19,020	106,715	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	32	633	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	594.38	168.59	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	23	252	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	13,671	42,485	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		125,735	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		56,156	16.00

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

Provider CCN: 15-1322 | Component CCN: 15-8517 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-4 | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | RHC II | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	305,430	305,430	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.008802	0.005529	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,688	1,689	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,061	1,421	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,749	3,110	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	305,430	305,430	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	330,209	330,209	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015549	0.010182	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,134	3,362	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,883	6,472	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	78	49	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	126.71	132.08	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	9	2	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,140	264	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		16,355	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,404	16.00

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

Provider CCN: 15-1322 | Component CCN: 15-8518 | Period: From 01/01/2019 To 12/31/2019 | Worksheet M-4 | Date/Time Prepared: 6/8/2020 8:34 am

Title XVIII | RHC III | Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	294,743	294,743	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.012892	0.011150	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,800	3,286	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	25,641	2,618	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	29,441	5,904	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	294,954	294,954	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	257,289	257,289	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.099816	0.020017	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	25,682	5,150	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	55,123	11,054	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	111	96	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	496.60	115.15	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	90	51	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	44,694	5,873	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		66,177	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		50,567	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1322 Component CCN: 15-8516	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 6/8/2020 8:34 am
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		691,758	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		08/29/2019	117,700	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		117,700	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		809,458	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		135,322	6.02
7.00	Total Medicare program liability (see instructions)		674,136	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 15-1322 Component CCN: 15-8517	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 6/8/2020 8:34 am
		RHC II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		29,891	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)		29,891	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		8,265	6.02
7.00	Total Medicare program liability (see instructions)		21,626	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: 15-1322 Component CCN: 15-8518	Period: From 01/01/2019 To 12/31/2019	Worksheet M-5 Date/Time Prepared: 6/8/2020 8:34 am
		RHC III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		66,638	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)		66,638	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		46,932	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		113,570	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00