

State Copy

Health Financial Systems GRAHAM HOSPITAL ASSOCIATION In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/26/2019 9:30 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/26/2019	Time: 9:30 am
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 11/19/2018 7. Contractor No. 06101 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GRAHAM HOSPITAL ASSOCIATION (14-0001) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 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		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	84,969	201,749	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0		0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	405,945	169		0	7.00
8.00	NURSING FACILITY	0				0	8.00
10.00	RURAL HEALTH CLINIC I	0		683,875		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	490,914	885,793	0	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 9:23 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 210 WEST WALNUT			PO Box:				1.00		
2.00	City: CANTON			State: IL		Zip Code: 61520-		County: FULTON		
		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		GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N
10.00	Hospital-Based NF		GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		COLEMAN CLINIC	143493	99914		01/01/2008	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019		20.00
21.00	Type of Control (see instructions)						2			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	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)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,384	0	0	0	121	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 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					1		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					07/01/2018	06/30/2019	36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					Y	Y	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 9:23 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)		Y				60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			20.00	1		60.01
			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)					0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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: 14-0001

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From 07/01/2018
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	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		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00	
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				Y	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?			N		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)					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
			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.					109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 9:23 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	482,141	
		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.	Y		Y	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		5.00	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/26/2019 9:23 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N		N		N		N	
156.00	Subprovider - IPF	N		N		N		N	
157.00	Subprovider - IRF	N		N		N		N	
158.00	SUBPROVIDER								
159.00	SNF	N		N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N		N	
161.00	CMHC			N		N		N	
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							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)							0	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)							9.99	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)					07/01/2018	06/30/2019		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/26/2019 9:23 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/18/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		
		Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N 1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		
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	10/02/2019	
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		
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		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/26/2019 9:23 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.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.	PAUL	TRACZEK		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715.858.6619	PTRACZEK@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/26/2019 9:23 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.	CPA		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

HFS Supplemental Information

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part IX
Date/Time Prepared:
11/26/2019 9:23 am

		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 9:23 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	38	13,870	0.00	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)		38	13,870	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	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)		43	15,695	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00 NURSING FACILITY	45.00	18	6,570		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		81				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 9:23 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)	3,320	980	6,222			1.00
2.00	HMO and other (see instructions)	1,305	121				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,320	980	6,222			7.00
8.00	INTENSIVE CARE UNIT	324	130	816			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		274	429			13.00
14.00	Total (see instructions)	3,644	1,384	7,467	0.00	470.32	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,468	0	4,084	0.00	17.28	19.00
20.00	NURSING FACILITY		3,072	5,561	0.00	15.81	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	17,301	23,018	87,149	0.00	77.06	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	580.47	27.00
28.00	Observation Bed Days		0	1,058			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			119			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/26/2019 9:23 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	940	399	2,069	1.00
2.00 HMO and other (see instructions)			332	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	940	399	2,069	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/26/2019 9:23 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	33,886,245	0	33,886,245	1,226,090.89	27.64	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,425,204	0	1,425,204	11,264.00	126.53	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		4,508,062	-23,818	4,484,244	28,225.88	158.87	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		3,470,942	0	3,470,942	145,880.49	23.79	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,000,406	0	1,000,406	36,599.28	27.33	9.00
10.00	Excluded area salaries (see instructions)		1,765,733	103,486	1,869,219	76,224.80	24.52	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,756,538	0	1,756,538	28,328.85	62.01	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,166,341	0	5,166,341			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		791,822	0	791,822			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		592,312	0	592,312			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,863,644	0	1,863,644			23.00
24.00	Wage-related costs (RHC/FQHC)		2,036,982	0	2,036,982			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	197,842	0	197,842	8,540.81	23.16	26.00
27.00	Administrative & General	5.00	6,882,228	0	6,882,228	251,412.40	27.37	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part II
Date/Time Prepared:
11/26/2019 9:23 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	1,216,152	0	1,216,152	13,770.33	88.32	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	851,646	-362	851,284	50,469.69	16.87	30.00
31.00	Laundry & Linen Service	27,164	0	27,164	2,391.89	11.36	31.00
32.00	Housekeeping	902,398	0	902,398	69,635.12	12.96	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	744,126	-460,317	283,809	18,217.93	15.58	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	0	460,317	460,317	30,995.53	14.85	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	554,893	0	554,893	10,923.21	50.80	38.00
39.00	Central Services and Supply	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	786,703	0	786,703	25,245.08	31.16	40.00
41.00	Medical Records & Medical Records Library	418,275	0	418,275	41,267.20	10.14	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part III
Date/Time Prepared:
11/26/2019 9:23 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	25,698,189	23,818	25,722,007	1,054,490.85	24.39	1.00
2.00	Excluded area salaries (see instructions)	2,766,139	103,486	2,869,625	112,824.08	25.43	2.00
3.00	Subtotal salaries (line 1 minus line 2)	22,932,050	-79,668	22,852,382	941,666.77	24.27	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,756,538	0	1,756,538	28,328.85	62.01	4.00
5.00	Subtotal wage-related costs (see inst.)	5,166,341	0	5,166,341	0.00	22.61	5.00
6.00	Total (sum of lines 3 thru 5)	29,854,929	-79,668	29,775,261	969,995.62	30.70	6.00
7.00	Total overhead cost (see instructions)	12,581,427	-362	12,581,065	522,869.19	24.06	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 11/26/2019 9:23 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		752,372	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		4,905	6.00
7.00	Employee Managed Care Program Administration Fees		280,593	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		6,216,810	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		15,033	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		180,731	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		292,443	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,343,294	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		44,056	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		168,234	21.00
22.00	Day Care Cost and Allowances		22,283	22.00
23.00	Tuition Reimbursement		130,259	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		10,451,013	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part V
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,089,919	10,451,013	1.00
2.00	Hospital	1,756,538	10,451,013	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	333,381	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-7

Date/Time Prepared:
11/26/2019 9:23 am

		1.00	2.00	3.00	4.00
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	50	0	50 12.00
13.00		RUB	7	0	7 13.00
14.00		RUA	266	0	266 14.00
15.00		RVC	419	0	419 15.00
16.00		RVB	103	0	103 16.00
17.00		RVA	672	0	672 17.00
18.00		RHC	224	0	224 18.00
19.00		RHB	152	0	152 19.00
20.00		RHA	444	0	444 20.00
21.00		RMC	17	0	17 21.00
22.00		RMB	17	0	17 22.00
23.00		RMA	18	0	18 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	4	0	4 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	4	0	4 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	14	0	14 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	23	0	23 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	7	0	7 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	16	0	16 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	10	0	10 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet S-7

Date/Time Prepared:
11/26/2019 9:23 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	1	0	1	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		2,468	0	2,468	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			99914	99914	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		1,000,406	50.65	Y	202.00
203.00	Recruitment		0	0.00	N	203.00
204.00	Retention of employees		0	0.00	N	204.00
205.00	Training		1,331	0.07	Y	205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		1,975,104			207.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-0001 Component CCN: 14-3493		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/26/2019 9:23 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			180 S MAIN STREET			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			CANTON IL 61520		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			08:30	15:00	07:30	17:30	07:30	11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y		4		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number			FARMINGTON CLINIC		143494		14.00	
14.01				CANTON CLINIC		143492		14.01	
14.02				CUBA CLINIC		143497		14.02	
14.03				COLEMAN CLINIC		143493		14.03	
				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			FULTON				2.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-0001

Period:

Worksheet S-8

Component CCN: 14-3493

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 9:23 am

RHC I

Cost

		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	17:30	07:30	17:30	07:30	17:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
Facility hours of operations (1)							
11.00	CLINIC	07:30	17:30	08:30	17:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/26/2019 9:23 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)			0.352315 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	6,292,932		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	2,536,963		5.00
6.00	Medicaid charges	45,330,929		6.00
7.00	Medicaid cost (line 1 times line 6)	15,970,766		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)	7,140,871		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)	7,140,871		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)	2,780,351	1,607,759	4,388,110 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	979,559	1,607,759	2,587,318 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)	979,559	1,607,759	2,587,318 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)	3,687,051		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	430,953		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	663,005		27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,024,046		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,297,469		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,884,787		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,025,658		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		7,311,885	7,311,885	-2,718,721	4,593,164	1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB		0	0	3,944	3,944	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,770,381	2,770,381	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	197,842	10,851,437	11,049,279	-131,770	10,917,509	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,882,228	7,877,439	14,759,667	-89,182	14,670,485	5.00
7.00	00700	OPERATION OF PLANT	851,646	1,970,896	2,822,542	-362	2,822,180	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,164	230,735	257,899	0	257,899	8.00
9.00	00900	HOUSEKEEPING	902,398	211,915	1,114,313	0	1,114,313	9.00
10.00	01000	DIETARY	744,126	652,694	1,396,820	-864,074	532,746	10.00
11.00	01100	CAFETERIA	0	0	0	864,074	864,074	11.00
13.00	01300	NURSING ADMINISTRATION	554,893	42,241	597,134	0	597,134	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,815	57,815	-46,416	11,399	14.00
15.00	01500	PHARMACY	786,703	1,511,005	2,297,708	0	2,297,708	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	418,275	277,144	695,419	0	695,419	16.00
20.00	02000	NURSING SCHOOL	1,060,674	184,661	1,245,335	0	1,245,335	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,007,218	386,863	3,394,081	2,196,470	5,590,551	30.00
31.00	03100	INTENSIVE CARE UNIT	670,886	35,027	705,913	-2,008	703,905	31.00
43.00	04300	NURSERY	0	30,369	30,369	5,188	35,557	43.00
44.00	04400	SKILLED NURSING FACILITY	1,000,406	107,684	1,108,090	0	1,108,090	44.00
45.00	04500	NURSING FACILITY	658,634	41,126	699,760	0	699,760	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,700,561	3,135,931	4,836,492	-1,928,559	2,907,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	10,241	10,241	52.01
53.00	05300	ANESTHESIOLOGY	1,425,204	151,045	1,576,249	0	1,576,249	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	854,917	821,102	1,676,019	-1,943	1,674,076	54.00
57.00	05700	CT SCAN	69,771	203,635	273,406	0	273,406	57.00
58.00	05800	MRI	69,636	127,497	197,133	0	197,133	58.00
60.00	06000	LABORATORY	1,655,869	1,976,716	3,632,585	0	3,632,585	60.00
65.00	06500	RESPIRATORY THERAPY	569,007	67,892	636,899	0	636,899	65.00
66.00	06600	PHYSICAL THERAPY	33,570	2,008,983	2,042,553	0	2,042,553	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	696,482	696,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,308,501	1,308,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,581,275	2,581,275	0	2,581,275	73.00
76.97	07697	CARDIAC REHABILITATION	182,110	103,274	285,384	0	285,384	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,176,553	9,981,130	15,157,683	-2,497,198	12,660,485	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	597,825	785,905	1,383,730	46,844	1,430,574	90.01
91.00	09100	EMERGENCY	3,305,953	268,036	3,573,989	71,545	3,645,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	435,751	657,287	1,093,038	23,702	1,116,740	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,839,820	54,650,644	88,490,464	-282,861	88,207,603	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	632	632	277,890	278,522	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	4,971	4,971	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	872	872	0	872	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	46,425	17,637	64,062	0	64,062	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	33,886,245	54,669,785	88,556,030	0	88,556,030	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet A

Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-707,913	3,885,251	1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	3,944	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,798	2,766,583	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-660,150	10,257,359	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,090,619	11,579,866	5.00
7.00	00700	OPERATION OF PLANT	0	2,822,180	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	257,899	8.00
9.00	00900	HOUSEKEEPING	-2,265	1,112,048	9.00
10.00	01000	DIETARY	-298,828	233,918	10.00
11.00	01100	CAFETERIA	-349,033	515,041	11.00
13.00	01300	NURSING ADMINISTRATION	-1,351	595,783	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,399	14.00
15.00	01500	PHARMACY	-1,541,759	755,949	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-13,182	682,237	16.00
20.00	02000	NURSING SCHOOL	-414,390	830,945	20.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,237,615	3,352,936	30.00
31.00	03100	INTENSIVE CARE UNIT	0	703,905	31.00
43.00	04300	NURSERY	0	35,557	43.00
44.00	04400	SKILLED NURSING FACILITY	-716	1,107,374	44.00
45.00	04500	NURSING FACILITY	0	699,760	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,907,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	10,241	52.01
53.00	05300	ANESTHESIOLOGY	-1,495,071	81,178	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,674,076	54.00
57.00	05700	CT SCAN	0	273,406	57.00
58.00	05800	MRI	0	197,133	58.00
60.00	06000	LABORATORY	-65,688	3,566,897	60.00
65.00	06500	RESPIRATORY THERAPY	0	636,899	65.00
66.00	06600	PHYSICAL THERAPY	0	2,042,553	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	696,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,308,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,581,275	73.00
76.97	07697	CARDIAC REHABILITATION	-55,872	229,512	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-8,649	12,651,836	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOUND CLINIC	-390,174	1,040,400	90.01
91.00	09100	EMERGENCY	-2,177,553	1,467,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-66,260	1,050,480	96.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,580,886	74,626,717	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	278,522	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
193.02	19302	FOUNDATION	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	194.01
194.02	07952	FRESENIUS	0	0	194.02
194.03	07953	RUCHFORD POB	0	4,971	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	194.05
194.06	07956	LEWISTON POB	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	872	194.07
194.08	07958	KELLEY HOME	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	194.10
194.11	07961	WELLNESS CENTER	0	64,062	194.11
200.00		TOTAL (SUM OF LINES 118 through 199)	-13,580,886	74,975,144	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet Non-CMS W
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	00101		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
20.00	NURSING SCHOOL	02000		20.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
45.00	NURSING FACILITY	04500		45.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
52.01	DELIVERY ROOM & LABOR ROOM	05201		52.01
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
90.01	WOUND CLINIC	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	DURABLE MEDICAL EQUIP-RENTED	09600		96.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	CANTON RHC RENTED SPACE	19201		192.01
193.00	NONPAID WORKERS	19300		193.00
193.02	FOUNDATION	19302		193.02
194.00	PHYSICIANS CLINIC	07950		194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	07951		194.01
194.02	FRESENIUS	07952		194.02
194.03	RUCHFORD POB	07953		194.03
194.04	EP COLEMAN RENTAL SPACE	07954		194.04
194.05	FARMINGTON POB	07955		194.05
194.06	LEWISTON POB	07956		194.06
194.07	OTHER RENTAL PROPERTY	07957		194.07
194.08	KELLEY HOME	07958		194.08
194.09	EMPLOYEE PURCHASE	07959		194.09
194.10	RETAIL PHARMACY	07960		194.10
194.11	WELLNESS CENTER	07961		194.11
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-6

Date/Time Prepared:
11/26/2019 9:23 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	460,317	403,757		1.00
	TOTALS		460,317	403,757		
	B - MAINTENANCE LABOR RECLASS					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	362	0		1.00
	TOTALS		362	0		
	C - OFFSITE CAPITAL RECLASS					
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	23,702		1.00
2.00	RUCHFORD POB	194.03	0	4,237		2.00
	TOTALS		0	27,939		
	D - PROPERTY INSURANCE RECLASS					
1.00	OTHER CAP REL COSTS	3.00	0	83,543		1.00
2.00	RUCHFORD POB	194.03	0	734		2.00
	TOTALS		0	84,277		
	E - DEPRECIATION RECLASS					
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	2,524		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,749,213		2.00
	TOTALS		0	2,751,737		
	F - RHC EXPENSE RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	90,990	2,128,680		1.00
2.00	PHYSICIANS PRIVATE OFFICES	192.00	103,124	174,404		2.00
	TOTALS		194,114	2,303,084		
	G - EMPLOYEE BENEFIT AUDIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,905		1.00
	TOTALS		0	4,905		
	H - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,308,501		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	1,308,501		
	I - MED SUP CHARGE TO PATIENTS RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	696,482		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
	TOTALS		0	696,482		
	J - RECLASS PHYSICIAN BENEFITS					
1.00	EMERGENCY	91.00	0	76,961		1.00
2.00	WOUND CLINIC	90.01	0	59,714		2.00
	TOTALS		0	136,675		
	K - RECLASS OB SALARIES					
1.00	NURSERY	43.00	5,694	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.01	10,241	0		2.00
	TOTALS		15,935	0		
500.00	Grand Total: Increases		670,728	7,717,357		500.00

RECLASSIFICATIONS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Date/Time Prepared:
11/26/2019 9:23 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	460,317	403,757	0		1.00
	TOTALS		460,317	403,757			
	B - MAINTENANCE LABOR RECLASS						
1.00	OPERATION OF PLANT	7.00	362	0	0		1.00
	TOTALS		362	0			
	C - OFFSITE CAPITAL RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	27,939	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	27,939			
	D - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	84,277	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	84,277			
	E - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,751,737	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	2,751,737			
	F - RHC EXPENSE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	194,114	2,303,084	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		194,114	2,303,084			
	G - EMPLOYEE BENEFIT AUDIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,905	0		1.00
	TOTALS		0	4,905			
	H - IMPLANT RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	234	0		1.00
2.00	OPERATING ROOM	50.00	0	1,308,166	0		2.00
3.00	EMERGENCY	91.00	0	101	0		3.00
	TOTALS		0	1,308,501			
	I - MED SUP CHARGE TO PATIENTS RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	46,182	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	7,265	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	2,008	0		3.00
4.00	NURSERY	43.00	0	506	0		4.00
5.00	OPERATING ROOM	50.00	0	620,393	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,943	0		6.00
7.00	WOUND CLINIC	90.01	0	12,870	0		7.00
8.00	EMERGENCY	91.00	0	5,315	0		8.00
	TOTALS		0	696,482			
	J - RECLASS PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	136,675	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	136,675			
	K - RECLASS OB SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	15,935	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		15,935	0			
500.00	Grand Total: Decreases		670,728	7,717,357			500.00

RECLASSIFICATIONS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/26/2019 9:23 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - CAFETERIA RECLASS									
1.00	CAFETERIA	11.00	460,317	403,757	DIETARY	10.00	460,317	403,757	1.00
	TOTALS		460,317	403,757	TOTALS		460,317	403,757	
B - MAINTENANCE LABOR RECLASS									
1.00	PHYSICIANS PRIVATE OFFICES	192.00	362	0	OPERATION OF PLANT	7.00	362	0	1.00
	TOTALS		362	0	TOTALS		362	0	
C - OFFSITE CAPITAL RECLASS									
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	23,702	CAP REL COSTS-BLDG & FIXT	1.00	0	27,939	1.00
2.00	RUCHFORD POB	194.03	0	4,237		0.00	0	0	2.00
	TOTALS		0	27,939	TOTALS		0	27,939	
D - PROPERTY INSURANCE RECLASS									
1.00	OTHER CAP REL COSTS	3.00	0	83,543	ADMINISTRATIVE & GENERAL	5.00	0	84,277	1.00
2.00	RUCHFORD POB	194.03	0	734		0.00	0	0	2.00
	TOTALS		0	84,277	TOTALS		0	84,277	
E - DEPRECIATION RECLASS									
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	2,524	CAP REL COSTS-BLDG & FIXT	1.00	0	2,751,737	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,749,213		0.00	0	0	2.00
	TOTALS		0	2,751,737	TOTALS		0	2,751,737	
F - RHC EXPENSE RECLASS									
1.00	ADULTS & PEDIATRICS	30.00	90,990	2,128,680	RURAL HEALTH CLINIC	88.00	194,114	2,303,084	1.00
2.00	PHYSICIANS PRIVATE OFFICES	192.00	103,124	174,404		0.00	0	0	2.00
	TOTALS		194,114	2,303,084	TOTALS		194,114	2,303,084	
G - EMPLOYEE BENEFIT AUDIT RECLASS									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,905	ADMINISTRATIVE & GENERAL	5.00	0	4,905	1.00
	TOTALS		0	4,905	TOTALS		0	4,905	
H - IMPLANT RECLASS									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,308,501	CENTRAL SERVICES & SUPPLY	14.00	0	234	1.00
2.00		0.00	0	0	OPERATING ROOM	50.00	0	1,308,166	2.00
3.00		0.00	0	0	EMERGENCY	91.00	0	101	3.00
	TOTALS		0	1,308,501	TOTALS		0	1,308,501	
I - MED SUP CHARGE TO PATIENTS RECLASS									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	696,482	CENTRAL SERVICES & SUPPLY	14.00	0	46,182	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	7,265	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	2,008	3.00
4.00		0.00	0	0	NURSERY	43.00	0	506	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	620,393	5.00
6.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	1,943	6.00
7.00		0.00	0	0	WOUND CLINIC	90.01	0	12,870	7.00
8.00		0.00	0	0	EMERGENCY	91.00	0	5,315	8.00
	TOTALS		0	696,482	TOTALS		0	696,482	
J - RECLASS PHYSICIAN BENEFITS									
1.00	EMERGENCY	91.00	0	76,961	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	136,675	1.00
2.00	WOUND CLINIC	90.01	0	59,714		0.00	0	0	2.00
	TOTALS		0	136,675	TOTALS		0	136,675	
K - RECLASS OB SALARIES									
1.00	NURSERY	43.00	5,694	0	ADULTS & PEDIATRICS	30.00	15,935	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.01	10,241	0		0.00	0	0	2.00
	TOTALS		15,935	0	TOTALS		15,935	0	
500.00	Grand Total: Increases		670,728	7,717,357	Grand Total: Decreases		670,728	7,717,357	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/26/2019 9:23 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,625,990	116,532	0	116,532	9,415	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	86,481,672	3,027,285	0	3,027,285	2,010,561	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	13,293,545	585,594	0	585,594	4,323,156	5.00
6.00	Movable Equipment	34,259,916	2,546,146	0	2,546,146	1,923,041	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139,661,123	6,275,557	0	6,275,557	8,266,173	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	139,661,123	6,275,557	0	6,275,557	8,266,173	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,733,107	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	87,498,396	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	9,555,983	0				5.00
6.00	Movable Equipment	34,883,021	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	137,670,507	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	137,670,507	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	7,311,885	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,311,885	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	7,311,885				1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	7,311,885				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	100,446,791	0	100,446,791	0.729618	60,955	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	2,340,695	0	2,340,695	0.017002	1,420	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	34,883,021	0	34,883,021	0.253380	21,168	2.00
3.00	Total (sum of lines 1-2)	137,670,507	0	137,670,507	1.000000	83,543	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	60,955	4,532,209	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	1,420	2,524	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	21,168	2,745,415	0	2.00
3.00	Total (sum of lines 1-2)	0	0	83,543	7,280,148	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-707,913	60,955	0	0	3,885,251	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	1,420	0	0	3,944	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	21,168	0	0	2,766,583	2.00
3.00	Total (sum of lines 1-2)	-707,913	83,543	0	0	6,655,778	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-355,427	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP REL COSTS-CARDIAC REHAB (chapter 2)			NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-53,644	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-7,347	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,736	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,884,826			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-349,033	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-13,182	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CARDIAC REHAB		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	DIETARY VENDOR REBATES/REFUNDS	B	-3,798	DIETARY	10.00	0	33.00
33.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.02
33.03	MEDICAL STAFF DUES	B	-16,250	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OTHER INCOME & PURCHASE GROUP	B	-99,170	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	HOUSEKEEPING OTHER REVENUE	B	-2,265	HOUSEKEEPING	9.00	0	33.05
33.06	DIETARY CONSULTANT AND EMP PURCHASE	B	-294,995	DIETARY	10.00	0	33.06
33.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.07
33.08	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09	NRSRG SVS CPR CLASS FEES	B	-1,351	NURSING ADMINISTRATION	13.00	0	33.09
33.10	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-130,938	PHARMACY	15.00	0	33.10
33.11	REFUND/EXP REBATE	B	-201	PHARMACY	15.00	0	33.11
33.12	CARDIAC OTHER REVENUE	B	-40,476	CARDIAC REHABILITATION	76.97	0	33.12
33.15	RHC OTHER INCOME	B	-8,649	RURAL HEALTH CLINIC	88.00	0	33.15
33.16	HME NON PATIENT SALES	B	-7,901	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.16
33.17	HME HME OTHER REVENUE	B	-10,457	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.17
33.18	GRI FOOD/NUTRI GUEST MEAL VOUCHERS	B	-35	DIETARY	10.00	0	33.18
33.20	NURSG SCHOOL(TUITN FEES BOOKS ETC.)	B	-414,390	NURSING SCHOOL	20.00	0	33.20
33.21	DONATIONS & DUES	A	-36,220	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22	CRNA CONTRACTED EXPENSE	A	-69,867	ANESTHESIOLOGY	53.00	0	33.22
33.23	CRNA SALARIES EXPENSE	A	-1,425,204	ANESTHESIOLOGY	53.00	0	33.23
33.26	CRNA BENEFITS EXPENSE	A	-344,439	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.26
33.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.27
33.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33.29	IL HOSPITAL PROVIDER TAX	A	-2,256,838	ADMINISTRATIVE & GENERAL	5.00	0	33.29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
33.31	PHONE SALARIES EXPENSE	A	-2,933	ADMINISTRATIVE & GENERAL	5.00	0	33.31
33.32	PHONE BENEFIT EXPENSE	A	-709	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.32
33.33	PHONE OTHER EXPENSE	A	-2,664	ADMINISTRATIVE & GENERAL	5.00	0	33.33
33.34	PHONE DEPRECIATION M/M EXPENSE	A	-62	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.34
33.35	IHA & AHA DUES LOBBYING PORTION	A	-22,299	ADMINISTRATIVE & GENERAL	5.00	0	33.35
33.36	IL HEALTHCARE ASSOCIATION LOBBYING	A	-716	SKILLED NURSING FACILITY	44.00	0	33.36
33.38	MARKETING DEPT SALARY EXPENSE	A	-127,374	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	MARKETING DEPT BENEFIT EXPENSE	A	-30,783	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.39
33.40	MARKETING DEPT OTHER EXPENSE	A	-294,313	ADMINISTRATIVE & GENERAL	5.00	0	33.40
33.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.41
33.43	PHYSICIAN RECRUITMENT	A	-171,567	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.44	LOAN FORGIVENESS EXPENSE	A	-284,219	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	RETAIL PHARMACY EXPENSES	A	-1,410,620	PHARMACY	15.00	0	33.45
33.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.46
33.47	SWAP INTEREST RATE EXPENSE	A	-352,486	CAP REL COSTS-BLDG & FIXT	1.00	11	33.47
33.49	GRI HME EMPLOYEE & GUEST REVENUE	B	-47,902	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.49
33.50	EMERGENCY ROOM OTHER INCOME	B	-1,600	EMERGENCY	91.00	0	33.50
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-13,580,886				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.

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8

Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet A-8-2

Date/Time Prepared:
11/26/2019 9:23 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	91.00	EMERGENCY	2,181,721	2,152,544	29,177	171,400	70	1.00
2.00	90.01	WOUND CLINIC	398,085	386,085	12,000	171,400	96	2.00
3.00	76.97	CARDIAC REHABILITATION	15,396	15,396	0	0	0	3.00
4.00	60.00	LABORATORY	57,000	0	57,000	171,400	500	4.00
5.00	60.00	LABORATORY	49,890	49,890	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	2,237,615	2,237,615	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,939,707	4,841,530	98,177		666	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	91.00	EMERGENCY	5,768	288	0	0	0	1.00
2.00	90.01	WOUND CLINIC	7,911	396	0	0	0	2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	41,202	2,060	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			54,881	2,744	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	91.00	EMERGENCY	0	5,768	23,409	2,175,953		1.00
2.00	90.01	WOUND CLINIC	0	7,911	4,089	390,174		2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	15,396		3.00
4.00	60.00	LABORATORY	0	41,202	15,798	15,798		4.00
5.00	60.00	LABORATORY	0	0	0	49,890		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,237,615		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	54,881	43,296	4,884,826		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP	
			0	1.00	1.01	2.00	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,885,251	3,885,251			1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	3,944	0	3,944		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,766,583			2,766,583	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,257,359	23,013	0	370	10,280,742
5.00	00500	ADMINISTRATIVE & GENERAL	11,579,866	420,899	0	1,115,172	2,337,382
7.00	00700	OPERATION OF PLANT	2,822,180	420,806	0	61,303	294,699
8.00	00800	LAUNDRY & LINEN SERVICE	257,899	55,501	0	1,869	9,404
9.00	00900	HOUSEKEEPING	1,112,048	46,750	0	9,869	312,394
10.00	01000	DIETARY	233,918	108,260	0	15,659	98,250
11.00	01100	CAFETERIA	515,041	28,940	0	0	159,353
13.00	01300	NURSING ADMINISTRATION	595,783	33,046	0	17,082	192,094
14.00	01400	CENTRAL SERVICES & SUPPLY	11,399	0	0	636	0
15.00	01500	PHARMACY	755,949	24,751	0	85,602	270,944
16.00	01600	MEDICAL RECORDS & LIBRARY	682,237	92,022	0	617	144,799
20.00	02000	NURSING SCHOOL	830,945	323,240	0	19,772	367,186
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,352,936	223,016	0	90,261	1,067,027
31.00	03100	INTENSIVE CARE UNIT	703,905	38,910	0	30,153	232,249
43.00	04300	NURSERY	35,557	11,284	0	3,560	1,971
44.00	04400	SKILLED NURSING FACILITY	1,107,374	94,432	0	26,749	346,323
45.00	04500	NURSING FACILITY	699,760	68,078	0	2,388	228,007
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,907,933	219,324	0	512,563	588,704
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
52.01	05201	DELIVERY ROOM & LABOR ROOM	10,241	33,439	0	383	3,545
53.00	05300	ANESTHESIOLOGY	81,178	13,167	0	4,525	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,674,076	121,365	0	409,163	295,957
57.00	05700	CT SCAN	273,406	0	0	19,184	24,153
58.00	05800	MRI	197,133	30,977	0	0	24,107
60.00	06000	LABORATORY	3,566,897	168,684	0	115,640	573,232
65.00	06500	RESPIRATORY THERAPY	636,899	2,027	0	17,117	196,980
66.00	06600	PHYSICAL THERAPY	2,042,553	130,425	0	10,162	11,621
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	696,482	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,308,501	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,581,275	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	229,512	28,671	3,944	30,168	57,713
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	12,651,836	578,538	0	85,846	1,752,007
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOUND CLINIC	1,040,400	34,618	0	3,006	102,486
91.00	09100	EMERGENCY	1,467,981	136,486	0	28,226	410,127
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,050,480	0	0	40,297	150,849
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,626,717	3,510,669	3,944	2,757,342	10,253,563
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	18,224	0	0	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	278,522	65,564	0	287	11,108
192.01	19201	CANTON RHC RENTED SPACE	0	130,974	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	FOUNDATION	0	0	0	0	0
194.00	07950	PHYSICIANS CLINIC	0	28,743	0	0	0
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0
194.02	07952	FRESENIUS	0	62,058	0	0	0
194.03	07953	RUCHFORD POB	4,971	0	0	0	0
194.04	07954	EP COLEMAN RENTAL SPACE	0	69,019	0	0	0
194.05	07955	FARMINGTON POB	0	0	0	0	0
194.06	07956	LEWISTON POB	0	0	0	0	0
194.07	07957	OTHER RENTAL PROPERTY	872	0	0	0	0
194.08	07958	KELLEY HOME	0	0	0	0	0
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0
194.10	07960	RETAIL PHARMACY	0	0	0	0	0
194.11	07961	WELLNESS CENTER	64,062	0	0	8,954	16,071
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP		
202.00	TOTAL (sum lines 118 through 201)	74,975,144	3,885,251	3,944	2,766,583	10,280,742	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,453,319	15,453,319				5.00
7.00	00700	OPERATION OF PLANT	3,598,988	934,384	4,533,372			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	324,673	84,293	83,298	492,264		8.00
9.00	00900	HOUSEKEEPING	1,481,061	384,519	70,165	11,370	1,947,115	9.00
10.00	01000	DIETARY	456,087	118,411	162,483	0	112,082	10.00
11.00	01100	CAFETERIA	703,334	182,602	43,434	0	29,961	11.00
13.00	01300	NURSING ADMINISTRATION	838,005	217,566	49,597	0	34,213	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,035	3,125	0	0	0	14.00
15.00	01500	PHARMACY	1,137,246	295,256	37,147	0	25,625	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	919,675	238,770	138,111	0	50,917	16.00
20.00	02000	NURSING SCHOOL	1,541,143	400,118	485,135	0	334,651	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,733,240	1,228,863	334,714	184,897	230,889	30.00
31.00	03100	INTENSIVE CARE UNIT	1,005,217	260,978	58,399	19,905	40,284	31.00
43.00	04300	NURSERY	52,372	13,597	16,936	3,507	11,683	43.00
44.00	04400	SKILLED NURSING FACILITY	1,574,878	408,876	141,728	73,919	97,765	44.00
45.00	04500	NURSING FACILITY	998,233	259,165	102,175	53,956	70,481	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,228,524	1,097,826	329,172	49,864	227,066	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	47,608	12,360	50,187	0	34,619	52.01
53.00	05300	ANESTHESIOLOGY	98,870	25,669	19,761	0	13,631	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,500,561	649,206	182,151	32,882	109,587	54.00
57.00	05700	CT SCAN	316,743	82,234	0	0	0	57.00
58.00	05800	MRI	252,217	65,482	46,492	0	32,071	58.00
60.00	06000	LABORATORY	4,424,453	1,148,694	253,170	1,228	134,698	60.00
65.00	06500	RESPIRATORY THERAPY	853,023	221,465	3,043	1,023	2,099	65.00
66.00	06600	PHYSICAL THERAPY	2,194,761	569,813	195,749	0	66,979	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	696,482	180,823	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,308,501	339,718	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,581,275	670,161	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	350,008	90,870	43,031	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,068,227	3,912,100	868,299	263	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,180,510	306,489	51,957	3,741	35,840	90.01
91.00	09100	EMERGENCY	2,042,820	530,365	204,846	55,709	141,305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,241,626	322,356	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,215,715	15,256,154	3,971,180	492,264	1,836,446	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	18,224	4,731	27,352	0	13,032	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	355,481	92,291	98,402	0	67,879	192.00
192.01	19201	CANTON RHC RENTED SPACE	130,974	34,004	196,572	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	28,743	7,462	43,139	0	29,758	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	62,058	16,112	93,140	0	0	194.02
194.03	07953	RUCHFORD POB	4,971	1,291	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	69,019	17,919	103,587	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	872	226	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	89,087	23,129	0	0	0	194.11
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	74,975,144	15,453,319	4,533,372	492,264	1,947,115	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	849,063					10.00
11.00	01100	CAFETERIA	0	959,331				11.00
13.00	01300	NURSING ADMINISTRATION	0	17,991	1,157,372			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	15,160		14.00
15.00	01500	PHARMACY	0	41,603	0	0	1,536,877	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67,990	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	51,061	0	5	54	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	351,012	154,794	392,422	621	9,942	30.00
31.00	03100	INTENSIVE CARE UNIT	39,635	30,637	77,668	103	2,188	31.00
43.00	04300	NURSERY	0	16,723	42,396	73	12	43.00
44.00	04400	SKILLED NURSING FACILITY	193,993	60,314	152,903	190	1,458	44.00
45.00	04500	NURSING FACILITY	264,423	53,563	135,788	62	115	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	96,159	243,776	6,050	13,356	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	5,140	13,032	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	18,574	47,087	88	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,622	0	502	3,134	54.00
57.00	05700	CT SCAN	0	3,461	0	157	145	57.00
58.00	05800	MRI	0	5,175	0	43	0	58.00
60.00	06000	LABORATORY	0	142,114	0	259	193	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,789	0	144	628	65.00
66.00	06600	PHYSICAL THERAPY	0	1,131	0	34	34	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,774	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,080	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	385	1,141,035	73.00
76.97	07697	CARDIAC REHABILITATION	0	10,109	0	10	161	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	588	344,849	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	20,630	52,300	399	9,626	90.01
91.00	09100	EMERGENCY	0	89,751	0	523	9,907	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	70	27	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	849,063	959,331	1,157,372	15,160	1,536,877	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
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)	849,063	959,331	1,157,372	15,160	1,536,877	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,415,463					16.00
20.00	02000	NURSING SCHOOL	0	2,812,167				20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	389,608	902,834	8,913,836	0	8,913,836	30.00
31.00	03100	INTENSIVE CARE UNIT	0	106,402	1,641,416	0	1,641,416	31.00
43.00	04300	NURSERY	0	0	157,299	0	157,299	43.00
44.00	04400	SKILLED NURSING FACILITY	21,796	664,633	3,392,453	0	3,392,453	44.00
45.00	04500	NURSING FACILITY	0	0	1,937,961	0	1,937,961	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	294,250	338,307	6,924,350	0	6,924,350	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	162,946	0	162,946	52.01
53.00	05300	ANESTHESIOLOGY	0	0	223,693	0	223,693	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,890	0	3,569,535	0	3,569,535	54.00
57.00	05700	CT SCAN	0	0	402,740	0	402,740	57.00
58.00	05800	MRI	0	0	401,480	0	401,480	58.00
60.00	06000	LABORATORY	109,458	0	6,214,267	0	6,214,267	60.00
65.00	06500	RESPIRATORY THERAPY	16,347	63,381	1,183,942	0	1,183,942	65.00
66.00	06600	PHYSICAL THERAPY	16,007	53,396	3,097,904	0	3,097,904	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	879,079	0	879,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,651,299	0	1,651,299	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	58,172	4,451,028	0	4,451,028	73.00
76.97	07697	CARDIAC REHABILITATION	0	39,071	533,260	0	533,260	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	313,934	289,990	20,798,250	0	20,798,250	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	115,909	1,777,401	0	1,777,401	90.01
91.00	09100	EMERGENCY	212,173	180,072	3,467,471	0	3,467,471	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	1,564,079	0	1,564,079	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,415,463	2,812,167	73,345,689	0	73,345,689	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	63,339	0	63,339	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	614,053	0	614,053	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	361,550	0	361,550	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	109,102	0	109,102	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	171,310	0	171,310	194.02
194.03	07953	RUCHFORD POB	0	0	6,262	0	6,262	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	190,525	0	190,525	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	1,098	0	1,098	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	112,216	0	112,216	194.11
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)	1,415,463	2,812,167	74,975,144	0	74,975,144	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-0001

Period:

From 07/01/2018

To 06/30/2019

Worksheet Non-CMS W

Date/Time Prepared:

11/26/2019 9:23 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	2	SQUARE FEET	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	3	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALA RIE	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	7	SQUARE FEET	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	FTES	11.00
13.00	NURSING ADMINISTRATION	10	FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
15.00	PHARMACY	12	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	13	TIME SPENT	16.00
20.00	NURSING SCHOOL	14	ASSIGNED TIME	20.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	23,013	0	23,383	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	420,899	0	1,115,172	5.00
7.00	00700	OPERATION OF PLANT	0	420,806	0	61,303	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	55,501	0	1,869	8.00
9.00	00900	HOUSEKEEPING	0	46,750	0	9,869	9.00
10.00	01000	DIETARY	0	108,260	0	15,659	10.00
11.00	01100	CAFETERIA	0	28,940	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	33,046	0	17,082	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	636	14.00
15.00	01500	PHARMACY	0	24,751	0	85,602	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	92,022	0	617	16.00
20.00	02000	NURSING SCHOOL	0	323,240	0	19,772	20.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	223,016	0	90,261	30.00
31.00	03100	INTENSIVE CARE UNIT	0	38,910	0	30,153	31.00
43.00	04300	NURSERY	0	11,284	0	3,560	43.00
44.00	04400	SKILLED NURSING FACILITY	0	94,432	0	26,749	44.00
45.00	04500	NURSING FACILITY	0	68,078	0	2,388	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	219,324	0	512,563	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	33,439	0	383	52.01
53.00	05300	ANESTHESIOLOGY	0	13,167	0	4,525	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,365	0	409,163	54.00
57.00	05700	CT SCAN	0	0	0	19,184	57.00
58.00	05800	MRI	0	30,977	0	0	58.00
60.00	06000	LABORATORY	0	168,684	0	115,640	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,027	0	17,117	65.00
66.00	06600	PHYSICAL THERAPY	0	130,425	0	10,162	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	28,671	3,944	30,168	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	578,538	0	85,846	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	34,618	0	3,006	90.01
91.00	09100	EMERGENCY	0	136,486	0	28,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	40,297	96.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,510,669	3,944	2,757,342	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	18,224	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	65,564	0	287	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	130,974	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	28,743	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	62,058	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	69,019	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	8,954	194.11
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,885,251	3,944	2,766,583	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			EMPLOYEE BENEFITS & GENERAL	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	23,383					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,327	1,541,398				5.00
7.00	00700	OPERATION OF PLANT	670	93,199	575,978			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21	8,408	10,583	76,382		8.00
9.00	00900	HOUSEKEEPING	710	38,354	8,915	1,764	106,362	9.00
10.00	01000	DIETARY	223	11,811	20,644	0	6,123	10.00
11.00	01100	CAFETERIA	362	18,214	5,518	0	1,637	11.00
13.00	01300	NURSING ADMINISTRATION	437	21,701	6,301	0	1,869	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	312	0	0	0	14.00
15.00	01500	PHARMACY	616	29,450	4,720	0	1,400	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	329	23,816	17,547	0	2,781	16.00
20.00	02000	NURSING SCHOOL	835	39,909	61,638	0	18,278	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,426	122,572	42,526	28,690	12,612	30.00
31.00	03100	INTENSIVE CARE UNIT	528	26,031	7,420	3,088	2,201	31.00
43.00	04300	NURSERY	4	1,356	2,152	544	638	43.00
44.00	04400	SKILLED NURSING FACILITY	787	40,783	18,007	11,470	5,340	44.00
45.00	04500	NURSING FACILITY	518	25,850	12,982	8,372	3,850	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,338	109,502	41,822	7,737	12,404	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	8	1,233	6,376	0	1,891	52.01
53.00	05300	ANESTHESIOLOGY	0	2,560	2,511	0	745	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	673	64,755	23,143	5,102	5,986	54.00
57.00	05700	CT SCAN	55	8,202	0	0	0	57.00
58.00	05800	MRI	55	6,531	5,907	0	1,752	58.00
60.00	06000	LABORATORY	1,303	114,576	32,166	190	7,358	60.00
65.00	06500	RESPIRATORY THERAPY	448	22,090	387	159	115	65.00
66.00	06600	PHYSICAL THERAPY	26	56,836	24,871	0	3,659	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	18,036	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	33,885	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	66,845	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	131	9,064	5,467	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,983	390,226	110,320	41	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	233	30,570	6,601	581	1,958	90.01
91.00	09100	EMERGENCY	932	52,901	26,026	8,644	7,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	343	32,153	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,321	1,521,731	504,550	76,382	100,316	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	472	3,475	0	712	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	25	9,206	12,502	0	3,708	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	3,392	24,975	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	744	5,481	0	1,626	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	1,607	11,834	0	0	194.02
194.03	07953	RUCHFORD POB	0	129	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	1,787	13,161	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	23	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	37	2,307	0	0	0	194.11
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)	23,383	1,541,398	575,978	76,382	106,362	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	162,720					10.00
11.00	01100	CAFETERIA	0	54,671				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,025	81,461			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	948		14.00
15.00	01500	PHARMACY	0	2,371	0	0	148,910	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,875	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	2,910	0	0	5	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,270	8,821	27,621	39	963	30.00
31.00	03100	INTENSIVE CARE UNIT	7,596	1,746	5,467	6	212	31.00
43.00	04300	NURSERY	0	953	2,984	5	1	43.00
44.00	04400	SKILLED NURSING FACILITY	37,178	3,437	10,762	12	141	44.00
45.00	04500	NURSING FACILITY	50,676	3,052	9,557	4	11	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,480	17,158	377	1,294	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	293	917	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	1,059	3,314	6	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,828	0	31	304	54.00
57.00	05700	CT SCAN	0	197	0	10	14	57.00
58.00	05800	MRI	0	295	0	3	0	58.00
60.00	06000	LABORATORY	0	8,099	0	16	19	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,299	0	9	61	65.00
66.00	06600	PHYSICAL THERAPY	0	64	0	2	3	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	111	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	193	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24	110,556	73.00
76.97	07697	CARDIAC REHABILITATION	0	576	0	1	16	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	37	33,413	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	1,176	3,681	25	933	90.01
91.00	09100	EMERGENCY	0	5,115	0	33	960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	4	3	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,720	54,671	81,461	948	148,910	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
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)	162,720	54,671	81,461	948	148,910	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
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Cost Center Description			MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	140,987					16.00
20.00	02000	NURSING SCHOOL	0	466,587				20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	38,808		665,625	0	665,625	30.00
31.00	03100	INTENSIVE CARE UNIT	0		123,358	0	123,358	31.00
43.00	04300	NURSERY	0		23,481	0	23,481	43.00
44.00	04400	SKILLED NURSING FACILITY	2,171		251,269	0	251,269	44.00
45.00	04500	NURSING FACILITY	0		185,338	0	185,338	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,309		958,308	0	958,308	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0		44,540	0	44,540	52.01
53.00	05300	ANESTHESIOLOGY	0		27,888	0	27,888	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,172		637,522	0	637,522	54.00
57.00	05700	CT SCAN	0		27,662	0	27,662	57.00
58.00	05800	MRI	0		45,520	0	45,520	58.00
60.00	06000	LABORATORY	10,903		458,954	0	458,954	60.00
65.00	06500	RESPIRATORY THERAPY	1,628		45,340	0	45,340	65.00
66.00	06600	PHYSICAL THERAPY	1,594		227,642	0	227,642	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		18,147	0	18,147	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		34,078	0	34,078	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		177,425	0	177,425	73.00
76.97	07697	CARDIAC REHABILITATION	0		78,038	0	78,038	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	31,269		1,233,673	0	1,233,673	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	0		83,382	0	83,382	90.01
91.00	09100	EMERGENCY	21,133		288,175	0	288,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		72,800	0	72,800	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	140,987	0	5,708,165	0	5,708,165	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		22,883	0	22,883	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		91,292	0	91,292	192.00
192.01	19201	CANTON RHC RENTED SPACE	0		159,341	0	159,341	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
193.02	19302	FOUNDATION	0		0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0		36,594	0	36,594	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0		0	0	0	194.01
194.02	07952	FRESENIUS	0		75,499	0	75,499	194.02
194.03	07953	RUCHFORD POB	0		129	0	129	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0		83,967	0	83,967	194.04
194.05	07955	FARMINGTON POB	0		0	0	0	194.05
194.06	07956	LEWISTON POB	0		0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0		23	0	23	194.07
194.08	07958	KELLEY HOME	0		0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0		0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0		0	0	0	194.10
194.11	07961	WELLNESS CENTER	0		11,298	0	11,298	194.11
200.00		Cross Foot Adjustments		466,587	466,587	0	466,587	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	140,987	466,587	6,655,778	0	6,655,778	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	375,640					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	30,653				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2,749,213			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,225	0	368	29,697,545		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,694		1,108,167	6,751,921	-15,453,319	5.00
7.00	00700	OPERATION OF PLANT	40,685	0	60,918	851,284	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,366	0	1,857	27,164	0	8.00
9.00	00900	HOUSEKEEPING	4,520		9,807	902,398	0	9.00
10.00	01000	DIETARY	10,467	0	15,561	283,809	0	10.00
11.00	01100	CAFETERIA	2,798	0	0	460,317	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,195	0	16,975	554,893	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	632	0	0	14.00
15.00	01500	PHARMACY	2,393	0	85,065	782,664	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,897	0	613	418,275	0	16.00
20.00	02000	NURSING SCHOOL	31,252	0	19,648	1,060,674	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,562	0	89,694	3,082,273	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,762	0	29,964	670,886	0	31.00
43.00	04300	NURSERY	1,091	0	3,538	5,694	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,130	0	26,581	1,000,406	0	44.00
45.00	04500	NURSING FACILITY	6,582	0	2,373	658,634	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,205	0	509,345	1,700,561	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	3,233	0	381	10,241	0	52.01
53.00	05300	ANESTHESIOLOGY	1,273	0	4,497	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,734	0	406,594	854,917	0	54.00
57.00	05700	CT SCAN	0	0	19,064	69,771	0	57.00
58.00	05800	MRI	2,995	0	0	69,636	0	58.00
60.00	06000	LABORATORY	16,309	0	114,914	1,655,869	0	60.00
65.00	06500	RESPIRATORY THERAPY	196	0	17,010	569,007	0	65.00
66.00	06600	PHYSICAL THERAPY	12,610	0	10,098	33,570	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,772	30,653	29,979	166,714	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	55,935	0	85,307	5,060,942	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	3,347	0	2,987	296,046	0	90.01
91.00	09100	EMERGENCY	13,196	0	28,049	1,184,716	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	40,044	435,751	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	339,424	30,653	2,740,030	29,619,033	-15,453,319	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,762	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,339	0	285	32,087	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	12,663	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,779	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	6,000	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	6,673	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	8,898	46,425	0	194.11
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALA RIE)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00			
202.00		Cost to be allocated (per Wkst. B, Part I)	3,885,251	3,944	2,766,583	10,280,742	5A	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.343017	0.128666	1.006318	0.346182		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				23,383		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000787		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:

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Cost Center Description			ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	59,521,825					5.00
7.00	00700	OPERATION OF PLANT	3,598,988	292,036				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	324,673	5,366	437,892			8.00
9.00	00900	HOUSEKEEPING	1,481,061	4,520	10,114	181,835		9.00
10.00	01000	DIETARY	456,087	10,467	0	10,467	53,598	10.00
11.00	01100	CAFETERIA	703,334	2,798	0	2,798	0	11.00
13.00	01300	NURSING ADMINISTRATION	838,005	3,195	0	3,195	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,035	0	0	0	0	14.00
15.00	01500	PHARMACY	1,137,246	2,393	0	2,393	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	919,675	8,897	0	4,755	0	16.00
20.00	02000	NURSING SCHOOL	1,541,143	31,252	0	31,252	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,733,240	21,562	164,476	21,562	22,158	30.00
31.00	03100	INTENSIVE CARE UNIT	1,005,217	3,762	17,706	3,762	2,502	31.00
43.00	04300	NURSERY	52,372	1,091	3,120	1,091	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,574,878	9,130	65,754	9,130	12,246	44.00
45.00	04500	NURSING FACILITY	998,233	6,582	47,996	6,582	16,692	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,228,524	21,205	44,356	21,205	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	47,608	3,233	0	3,233	0	52.01
53.00	05300	ANESTHESIOLOGY	98,870	1,273	0	1,273	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,500,561	11,734	29,250	10,234	0	54.00
57.00	05700	CT SCAN	316,743	0	0	0	0	57.00
58.00	05800	MRI	252,217	2,995	0	2,995	0	58.00
60.00	06000	LABORATORY	4,424,453	16,309	1,092	12,579	0	60.00
65.00	06500	RESPIRATORY THERAPY	853,023	196	910	196	0	65.00
66.00	06600	PHYSICAL THERAPY	2,194,761	12,610	0	6,255	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	696,482	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,308,501	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,581,275	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	350,008	2,772	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,068,227	55,935	234	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1,180,510	3,347	3,328	3,347	0	90.01
91.00	09100	EMERGENCY	2,042,820	13,196	49,556	13,196	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,241,626	0	0	0	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,762,396	255,820	437,892	171,500	53,598	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	18,224	1,762	0	1,217	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	355,481	6,339	0	6,339	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	130,974	12,663	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	28,743	2,779	0	2,779	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	62,058	6,000	0	0	0	194.02
194.03	07953	RUCHFORD POB	4,971	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	69,019	6,673	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	872	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	89,087	0	0	0	0	194.11
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)	15,453,319	4,533,372	492,264	1,947,115	849,063	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.259624	15.523333	1.124168	10.708142	15.841319	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	1,541,398	575,978	76,382	106,362	162,720	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.025896	1.972284	0.174431	0.584937	3.035934	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	27,994					11.00
13.00	01300	NURSING ADMINISTRATION	525	13,322				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,057,183			14.00
15.00	01500	PHARMACY	1,214	0	0	3,306,174		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,984	0	0	0	20,781	16.00
20.00	02000	NURSING SCHOOL	1,490	0	1,279	117	0	20.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,517	4,517	166,220	21,387	5,720	30.00
31.00	03100	INTENSIVE CARE UNIT	894	894	27,548	4,706	0	31.00
43.00	04300	NURSERY	488	488	19,411	26	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,760	1,760	50,919	3,137	320	44.00
45.00	04500	NURSING FACILITY	1,563	1,563	16,517	247	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,806	2,806	1,619,152	28,731	4,320	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	150	150	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	542	542	23,679	29	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,448	0	134,241	6,741	615	54.00
57.00	05700	CT SCAN	101	0	42,136	313	0	57.00
58.00	05800	MRI	151	0	11,588	0	0	58.00
60.00	06000	LABORATORY	4,147	0	69,414	415	1,607	60.00
65.00	06500	RESPIRATORY THERAPY	665	0	38,514	1,351	240	65.00
66.00	06600	PHYSICAL THERAPY	33	0	8,977	73	235	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	474,589	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	824,312	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	103,051	2,454,630	0	73.00
76.97	07697	CARDIAC REHABILITATION	295	0	2,581	346	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	157,421	741,848	4,609	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	602	602	106,779	20,707	0	90.01
91.00	09100	EMERGENCY	2,619	0	139,994	21,312	3,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	18,734	58	0	96.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,994	13,322	4,057,056	3,306,174	20,781	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	127	0	0	192.00
192.01	19201	CANTON RHC RENTED SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	FRESENIUS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
194.11	07961	WELLNESS CENTER	0	0	0	0	0	194.11
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)	959,331	1,157,372	15,160	1,536,877	1,415,463	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	34.269165	86.876745	0.003737	0.464851	68.113325	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	54,671	81,461	948	148,910	140,987	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.952954	6.114773	0.000234	0.045040	6.784418	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING SCHOOL	
		(ASSIGNED TIME)	
		20.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
20.00	02000	NURSING SCHOOL	20.00
		323,895	
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
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
		103,985	
		12,255	
		0	
		76,550	
		0	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	52.01
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.97	07697	CARDIAC REHABILITATION	76.97
		38,965	
		0	
		0	
		0	
		0	
		0	
		0	
		7,300	
		6,150	
		0	
		0	
		6,700	
		4,500	
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	WOUND CLINIC	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
		33,400	
		0	
		0	
		13,350	
		20,740	
OTHER REIMBURSABLE COST CENTERS			
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	96.00
		0	
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		323,895	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.01	19201	CANTON RHC RENTED SPACE	192.01
193.00	19300	NONPAID WORKERS	193.00
193.02	19302	FOUNDATION	193.02
194.00	07950	PHYSICIANS CLINIC	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	194.01
194.02	07952	FRESENIUS	194.02
194.03	07953	RUCHFORD POB	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	194.04
194.05	07955	FARMINGTON POB	194.05
194.06	07956	LEWISTON POB	194.06
194.07	07957	OTHER RENTAL PROPERTY	194.07
194.08	07958	KELLEY HOME	194.08
194.09	07959	EMPLOYEE PURCHASE	194.09
194.10	07960	RETAIL PHARMACY	194.10
194.11	07961	WELLNESS CENTER	194.11
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		2,812,167	
		8.682341	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING SCHOOL		
		(ASSIGNED TIME)		
		20.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	466,587		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.440550		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

Worksheet C
Part I
Date/Time Prepared:
11/26/2019 9:23 am

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COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet C Part I Date/Time Prepared: 11/26/2019 9:23 am	
				Title XVIII			Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	11,465,755		11,465,755			30.00	
31.00	03100	INTENSIVE CARE UNIT	2,122,364		2,122,364			31.00	
43.00	04300	NURSERY	348,889		348,889			43.00	
44.00	04400	SKILLED NURSING FACILITY	1,975,104		1,975,104			44.00	
45.00	04500	NURSING FACILITY	1,054,435		1,054,435			45.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	6,905,585	17,391,881	24,297,466	0.284982	0.000000	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
52.01	05201	DELIVERY ROOM & LABOR ROOM	631,236	101,167	732,403	0.222481	0.000000	52.01	
53.00	05300	ANESTHESIOLOGY	2,261,873	5,392,826	7,654,699	0.029223	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,070,630	18,174,043	20,244,673	0.176320	0.000000	54.00	
57.00	05700	CT SCAN	2,340,512	13,998,657	16,339,169	0.024649	0.000000	57.00	
58.00	05800	MRI	245,049	4,452,189	4,697,238	0.085472	0.000000	58.00	
60.00	06000	LABORATORY	5,674,737	23,943,054	29,617,791	0.209815	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	2,110,329	3,665,470	5,775,799	0.204983	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,977,094	7,438,049	9,415,143	0.329034	0.000000	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,110,465	1,898,049	4,008,514	0.219303	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,868,864	2,336,009	5,204,873	0.317260	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	6,392,590	6,130,118	12,522,708	0.355437	0.000000	73.00	
76.97	07697	CARDIAC REHABILITATION	1,648	1,038,678	1,040,326	0.512589	0.000000	76.97	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	19,869,019	19,869,019			88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00	
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.01	09001	WOUND CLINIC	35,820	4,334,627	4,370,447	0.406686	0.000000	90.01	
91.00	09100	EMERGENCY	3,780,400	15,758,623	19,539,023	0.177464	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	348,309	1,359,940	1,708,249	0.758348	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	4,178,273	4,178,273	0.374336	0.000000	96.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	56,721,688	151,460,672	208,182,360			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	56,721,688	151,460,672	208,182,360			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			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
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.284982			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.222481			52.01
53.00	05300	ANESTHESIOLOGY	0.029223			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176320			54.00
57.00	05700	CT SCAN	0.024649			57.00
58.00	05800	MRI	0.085472			58.00
60.00	06000	LABORATORY	0.210349			60.00
65.00	06500	RESPIRATORY THERAPY	0.204983			65.00
66.00	06600	PHYSICAL THERAPY	0.329034			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.219303			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317260			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355437			73.00
76.97	07697	CARDIAC REHABILITATION	0.512589			76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0.000000			90.00
90.01	09001	WOUND CLINIC	0.407622			90.01
91.00	09100	EMERGENCY	0.178662			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.758348			92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.374336			96.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part I
Date/Time Prepared:
11/26/2019 9:23 am

			Title XVIII		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	665,625	0	665,625	7,280	91.43	30.00	
31.00	INTENSIVE CARE UNIT	123,358		123,358	816	151.17	31.00	
43.00	NURSERY	23,481		23,481	429	54.73	43.00	
44.00	SKILLED NURSING FACILITY	251,269		251,269	4,084	61.53	44.00	
45.00	NURSING FACILITY	185,338		185,338	5,561	33.33	45.00	
200.00	Total (lines 30 through 199)	1,249,071		1,249,071	18,170		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	3,320	303,548					30.00
31.00	INTENSIVE CARE UNIT	324	48,979					31.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	2,468	151,856					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	6,112	504,383					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/26/2019 9:23 am

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)	Hospital Inpatient Program Charges	PPS 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	958,308	24,297,466	0.039441	3,189,611	125,801	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	44,540	732,403	0.060814	7,859	478	52.01
53.00	05300	ANESTHESIOLOGY	27,888	7,654,699	0.003643	504,605	1,838	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	637,522	20,244,673	0.031491	1,000,686	31,513	54.00
57.00	05700	CT SCAN	27,662	16,339,169	0.001693	1,267,055	2,145	57.00
58.00	05800	MRI	45,520	4,697,238	0.009691	111,180	1,077	58.00
60.00	06000	LABORATORY	458,954	29,617,791	0.015496	2,789,623	43,228	60.00
65.00	06500	RESPIRATORY THERAPY	45,340	5,775,799	0.007850	1,220,098	9,578	65.00
66.00	06600	PHYSICAL THERAPY	227,642	9,415,143	0.024178	681,250	16,471	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	18,147	4,008,514	0.004527	1,048,228	4,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,078	5,204,873	0.006547	1,666,661	10,912	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	177,425	12,522,708	0.014168	3,195,726	45,277	73.00
76.97	07697	CARDIAC REHABILITATION	78,038	1,040,326	0.075013	1,648	124	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,233,673	19,869,019	0.062090	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	83,382	4,370,447	0.019079	10,029	191	90.01
91.00	09100	EMERGENCY	288,175	19,539,023	0.014749	2,167,079	31,962	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	96,735	1,708,249	0.056628	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	72,800	4,178,273	0.017423	0	0	96.00
200.00		Total (lines 50 through 199)	4,555,829	191,215,813		18,861,338	325,340	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part III Date/Time Prepared: 11/26/2019 9:23 am		
					Title XVIII		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	902,834	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	106,402	0	0	0	0	31.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	664,633	0	0	0	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00		
200.00		Total (lines 30 through 199)	0	1,673,869	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	902,834	7,280	124.02	3,320	30.00			
31.00	03100	INTENSIVE CARE UNIT		106,402	816	130.39	324	31.00			
43.00	04300	NURSERY		0	429	0.00	0	43.00			
44.00	04400	SKILLED NURSING FACILITY		664,633	4,084	162.74	2,468	44.00			
45.00	04500	NURSING FACILITY		0	5,561	0.00	0	45.00			
200.00		Total (lines 30 through 199)		1,673,869	18,170		6,112	200.00			
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost							
			9.00	13.00							
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	411,746	0				30.00			
31.00	03100	INTENSIVE CARE UNIT	42,246	0				31.00			
43.00	04300	NURSERY	0	0				43.00			
44.00	04400	SKILLED NURSING FACILITY	401,642					44.00			
45.00	04500	NURSING FACILITY	0					45.00			
200.00		Total (lines 30 through 199)	855,634	0				200.00			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet D
Part IV
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	338,307	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	63,381	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	53,396	0	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	58,172	0	0 73.00
76.97	07697	CARDIAC REHABILITATION	0	0	39,071	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	289,990	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	WOUND CLINIC	0	0	115,909	0	0 90.01
91.00	09100	EMERGENCY	0	0	180,072	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	131,209	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
200.00		Total (lines 50 through 199)	0	0	1,269,507	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/26/2019 9:23 am	
			Title XVIII		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	338,307	338,307	24,297,466	0.013924	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	732,403	0.000000	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	7,654,699	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,244,673	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	16,339,169	0.000000	57.00
58.00	05800	MRI	0	0	0	4,697,238	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	29,617,791	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	63,381	63,381	5,775,799	0.010974	65.00
66.00	06600	PHYSICAL THERAPY	0	53,396	53,396	9,415,143	0.005671	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,008,514	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,204,873	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	58,172	58,172	12,522,708	0.004645	73.00
76.97	07697	CARDIAC REHABILITATION	0	39,071	39,071	1,040,326	0.037556	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	289,990	289,990	19,869,019	0.014595	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC	0	115,909	115,909	4,370,447	0.026521	90.01
91.00	09100	EMERGENCY	0	180,072	180,072	19,539,023	0.009216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	131,209	131,209	1,708,249	0.076809	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	4,178,273	0.000000	96.00
200.00		Total (lines 50 through 199)	0	1,269,507	1,269,507	191,215,813		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/26/2019 9:23 am

				Title XVIII		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	0.013924	3,189,611	44,412	4,373,836	60,901	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.000000	7,859	0	848	0	52.01
53.00	05300	ANESTHESIOLOGY	0.000000	504,605	0	536,198	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,000,686	0	5,466,288	0	54.00
57.00	05700	CT SCAN	0.000000	1,267,055	0	4,842,192	0	57.00
58.00	05800	MRI	0.000000	111,180	0	1,232,881	0	58.00
60.00	06000	LABORATORY	0.000000	2,789,623	0	3,645,338	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.010974	1,220,098	13,389	856,031	9,394	65.00
66.00	06600	PHYSICAL THERAPY	0.005671	681,250	3,863	32,714	186	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,048,228	0	57,283	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,666,661	0	632,400	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.004645	3,195,726	14,844	1,854,590	8,615	73.00
76.97	07697	CARDIAC REHABILITATION	0.037556	1,648	62	514,752	19,332	76.97
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.014595	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.026521	10,029	266	1,655,154	43,896	90.01
91.00	09100	EMERGENCY	0.009216	2,167,079	19,972	4,036,465	37,200	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.076809	0	0	1,352,139	103,856	92.00
	OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)		18,861,338	96,808	31,089,109	283,380	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 11/26/2019 9:23 am
			Title XVIII		Hospital	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	52.01	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MRI	0	0	58.00	
60.00	06000	LABORATORY	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00	
90.00	09000	CLINIC	0	0	90.00	
90.01	09001	WOUND CLINIC	0	0	90.01	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00	
200.00		Total (lines 50 through 199)	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/26/2019 9:23 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.284982	4,373,836	0	0	1,246,465	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM		0.222481	848	0	0	189	52.01
53.00	05300	ANESTHESIOLOGY		0.029223	536,198	0	0	15,669	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.176320	5,466,288	0	0	963,816	54.00
57.00	05700	CT SCAN		0.024649	4,842,192	0	0	119,355	57.00
58.00	05800	MRI		0.085472	1,232,881	0	0	105,377	58.00
60.00	06000	LABORATORY		0.209815	3,645,338	0	0	764,847	60.00
65.00	06500	RESPIRATORY THERAPY		0.204983	856,031	0	0	175,472	65.00
66.00	06600	PHYSICAL THERAPY		0.329034	32,714	0	0	10,764	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.219303	57,283	0	0	12,562	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.317260	632,400	0	0	200,635	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.355437	1,854,590	0	2,790	659,190	73.00
76.97	07697	CARDIAC REHABILITATION		0.512589	514,752	0	0	263,856	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0.000000				0	89.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC		0.406686	1,655,154	0	0	673,128	90.01
91.00	09100	EMERGENCY		0.177464	4,036,465	0	0	716,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.758348	1,352,139	0	0	1,025,392	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0.374336	0	0	0	0	96.00
200.00		Subtotal (see instructions)			31,089,109	0	2,790	6,953,044	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			31,089,109	0	2,790	6,953,044	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/26/2019 9:23 am	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0					52.01
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	992					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
90.00	09000	CLINIC	0	0					90.00
90.01	09001	WOUND CLINIC	0	0					90.01
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0					96.00
200.00		Subtotal (see instructions)	0	992					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	992					202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/26/2019 9:23 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	338,307	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	63,381	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	53,396	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	58,172	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	39,071	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	289,990	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	115,909	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	180,072	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	0	96.00
200.00		Total (lines 50 through 199)	0	0	1,138,298	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/26/2019 9:23 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	338,307	338,307	24,297,466	0.013924	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM		0	0	0	732,403	0.000000	52.01
53.00	05300	ANESTHESIOLOGY		0	0	0	7,654,699	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	20,244,673	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	16,339,169	0.000000	57.00
58.00	05800	MRI		0	0	0	4,697,238	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	29,617,791	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY		0	63,381	63,381	5,775,799	0.010974	65.00
66.00	06600	PHYSICAL THERAPY		0	53,396	53,396	9,415,143	0.005671	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	4,008,514	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	5,204,873	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	58,172	58,172	12,522,708	0.004645	73.00
76.97	07697	CARDIAC REHABILITATION		0	39,071	39,071	1,040,326	0.037556	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	289,990	289,990	19,869,019	0.014595	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00
90.01	09001	WOUND CLINIC		0	115,909	115,909	4,370,447	0.026521	90.01
91.00	09100	EMERGENCY		0	180,072	180,072	19,539,023	0.009216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	1,708,249	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0	0	0	4,178,273	0.000000	96.00
200.00		Total (lines 50 through 199)		0	1,138,298	1,138,298	191,215,813		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/26/2019 9:23 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.013924	740	10	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	7,252	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	20,438	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.010974	297,264	3,262	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.005671	1,294,346	7,340	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	244,697	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.004645	303,110	1,408	0	0	73.00
76.97	07697	CARDIAC REHABILITATION		0.037556	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.014595	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0.000000	0	0	0	0	89.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC		0.026521	21,407	568	0	0	90.01
91.00	09100	EMERGENCY		0.009216	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		0.000000	0	0	0	0	96.00
200.00		Total (lines 50 through 199)			2,189,254	12,588	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2018 To 06/30/2019	Worksheet D Part IV Date/Time Prepared: 11/26/2019 9:23 am
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00	
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0	52.01	
53.00	05300	ANESTHESIOLOGY	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MRI	0	0	58.00	
60.00	06000	LABORATORY	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00	
90.00	09000	CLINIC	0	0	90.00	
90.01	09001	WOUND CLINIC	0	0	90.01	
91.00	09100	EMERGENCY	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00	
200.00		Total (lines 50 through 199)	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/26/2019 9:23 am	
			Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.284982	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.222481	0	0	0	0	52.01
53.00	05300	ANESTHESIOLOGY	0.029223	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176320	0	1	27	0	54.00
57.00	05700	CT SCAN	0.024649	0	0	0	0	57.00
58.00	05800	MRI	0.085472	0	0	1	0	58.00
60.00	06000	LABORATORY	0.209815	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.204983	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.329034	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.219303	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317260	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355437	0	449	1,282	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.512589	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.406686	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.177464	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.758348	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.374336	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	450	1,310	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	450	1,310	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part V Date/Time Prepared: 11/26/2019 9:23 am		
			Title XVIII		Skilled Nursing Facility		PPS		
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0					52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0	0					52.01
53.00	05300	ANESTHESIOLOGY	0	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5					54.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	160	456					73.00
76.97	07697	CARDIAC REHABILITATION	0	0					76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
90.00	09000	CLINIC	0	0					90.00
90.01	09001	WOUND CLINIC	0	0					90.01
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0					96.00
200.00		Subtotal (see instructions)	160	461					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	160	461					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	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)		7,280	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,280	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)		6,222	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,320	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		8,913,836	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		8,913,836	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)		8,913,836	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,224.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,065,108	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)		4,065,108	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/26/2019 9:23 am

		Title XVIII		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)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,641,416	816	2,011.54	324	651,739
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					4,490,331
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,207,178
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					806,519
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					422,148
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,228,667
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,978,511
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					1,058
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,224.43
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,295,447

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet D-1

Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	665,625	8,913,836	0.074673	1,295,447	96,735 90.00
91.00	Nursing School cost	902,834	8,913,836	0.101285	1,295,447	131,209 91.00
92.00	Allied health cost	0	8,913,836	0.000000	1,295,447	0 92.00
93.00	All other Medical Education	0	8,913,836	0.000000	1,295,447	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,084	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,084	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)		4,084	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,468	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,392,453	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,392,453	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,392,453	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1	
				Component CCN: 14-5572		Date/Time Prepared: 11/26/2019 9:23 am	
				Title XVIII		Skilled Nursing Facility	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						3,392,453 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						830.67 71.00
72.00	Program routine service cost (line 9 x line 71)						2,050,094 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						2,050,094 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						2,050,094 83.00
84.00	Program inpatient ancillary services (see instructions)						662,733 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						2,712,827 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0001 Component CCN: 14-5572		Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/26/2019 9:23 am	
			Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 9:23 am	
			Title XVIII	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		4,858,760		30.00
31.00	03100	INTENSIVE CARE UNIT		1,133,528		31.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.284982	3,189,611	908,982	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
52.01	05201	DELIVERY ROOM & LABOR ROOM	0.222481	7,859	1,748	52.01
53.00	05300	ANESTHESIOLOGY	0.029223	504,605	14,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176320	1,000,686	176,441	54.00
57.00	05700	CT SCAN	0.024649	1,267,055	31,232	57.00
58.00	05800	MRI	0.085472	111,180	9,503	58.00
60.00	06000	LABORATORY	0.210349	2,789,623	586,794	60.00
65.00	06500	RESPIRATORY THERAPY	0.204983	1,220,098	250,099	65.00
66.00	06600	PHYSICAL THERAPY	0.329034	681,250	224,154	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.219303	1,048,228	229,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.317260	1,666,661	528,765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355437	3,195,726	1,135,879	73.00
76.97	07697	CARDIAC REHABILITATION	0.512589	1,648	845	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.407622	10,029	4,088	90.01
91.00	09100	EMERGENCY	0.178662	2,167,079	387,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.758348	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.374336	0	0	96.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		18,861,338	4,490,331	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		18,861,338		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/26/2019 9:23 am	
		Title XVIII	Skilled Nursing Facility	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		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	0.284982	740	211	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
52.01	05201 DELIVERY ROOM & LABOR ROOM	0.222481	0	0	52.01
53.00	05300 ANESTHESIOLOGY	0.029223	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.176320	7,252	1,279	54.00
57.00	05700 CT SCAN	0.024649	0	0	57.00
58.00	05800 MRI	0.085472	0	0	58.00
60.00	06000 LABORATORY	0.210349	20,438	4,299	60.00
65.00	06500 RESPIRATORY THERAPY	0.204983	297,264	60,934	65.00
66.00	06600 PHYSICAL THERAPY	0.329034	1,294,346	425,884	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.219303	244,697	53,663	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.317260	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.355437	303,110	107,737	73.00
76.97	07697 CARDIAC REHABILITATION	0.512589	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WOUND CLINIC	0.407622	21,407	8,726	90.01
91.00	09100 EMERGENCY	0.178662	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.758348	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.374336	0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,189,254	662,733	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,189,254		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,530,935	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		4,547,255	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		20,294	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		39.78	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.80	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.16	31.00
32.00	Sum of lines 30 and 31		22.96	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.16	33.00
34.00	Disproportionate share adjustment (see instructions)		123,995	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/26/2019 9:23 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		6,766,695,164	8,272,872,447	35.00
35.01	Factor 3 (see instructions)		0.000056641	0.000064927	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		383,272	537,133	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		96,606	401,746	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		498,352		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		6,720,831		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		7,631,368		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			7,631,368	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			490,518	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			1,255,358	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			453,992	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			96,808	58.00
59.00	Total (sum of amounts on lines 49 through 58)			9,928,044	59.00
60.00	Primary payer payments			4,762	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			9,923,282	61.00
62.00	Deductibles billed to program beneficiaries			847,428	62.00
63.00	Coinsurance billed to program beneficiaries			19,257	63.00
64.00	Allowable bad debts (see instructions)			319,856	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			207,906	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			255,652	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			9,264,503	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-17,367	70.93
70.94	HRR adjustment amount (see instructions)			-94,793	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part A Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	133,160	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	752,439	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,037,942	71.00
71.01	Sequestration adjustment (see instructions)		200,759	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,752,214	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		84,969	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		38,892	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		3,834	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
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 inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet DSH

Date/Time Prepared:
11/26/2019 9:23 am

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.80	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	20.16	0.00			20.16	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	22.96	0.00			20.16	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	SCH				SCH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	39.78	0.00			39.78	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	8.16	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,384	0			1,384	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	121	0			121	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,505	0			1,505	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	7,467	0			7,467	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	7,467	0			7,467	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	20.16	0.00			20.16	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE			Provider CCN: 14-0001		Period: From 07/01/2018 To 06/30/2019		Worksheet DSH Date/Time Prepared: 11/26/2019 9:23 am	
			Title XVIII		Hospital		PPS	
			Original .mcrx Values		Adjusted .mcax Values		Revised	
			Condition	Percentage	Condition	Percentage	Condition	
			1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE								
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	8.16		0.00	False	28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	True	29.00	
30.00	Line 28 or 29 as applicable		8.16		0.00		30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		8.16		0.00		31.00	
			Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
			1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE								
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00	
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00	
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00	
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00	
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00	

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet DSH

Date/Time Prepared:
11/26/2019 9:23 am

Title XVIII

Hospital

PPS

		Revised		
		Percentage		
		6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	5.85		29.00
30.00	Line 28 or 29 as applicable	5.85		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2019 9:23 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,530,935	0	1,530,935		1,530,935
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4,547,255	0		4,547,255	4,547,255
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00	20,294	0	8,465	11,829	20,294
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0816	0.0816	0.0816	0.0816	
11.00	Disproportionate share adjustment (see instructions)	34.00	123,995	0	31,231	92,764	123,995
11.01	Uncompensated care payments	36.00	498,352	0	96,606	401,746	498,352
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	6,720,831	0	1,667,237	5,053,594	6,720,831
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	7,631,368	0	1,942,014	5,689,354	7,631,368
15.00	Total payment for inpatient operating costs (see instructions)	49.00	7,631,368	0	1,942,014	5,689,354	7,631,368
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	490,518	0	123,638	366,880	490,518
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/26/2019 9:23 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	2,065,652	6,056,234	8,121,886
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	488,741	0	123,190	365,551	488,741
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	1,777	0	448	1,329	1,777
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	490,518	0	123,638	366,880	490,518
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.064464	0.124242	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			133,160		133,160
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				752,439	752,439
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		992	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,669,664	2.00
3.00	OPPS payments		5,659,469	3.00
4.00	Outlier payment (see instructions)		3,987	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.862	5.00
6.00	Line 2 times line 5		5,749,250	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		98.51	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		283,380	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		992	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,790	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)		2,790	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		2,790	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,798	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)		992	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)		5,946,836	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		81,043	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,066,483	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		4,800,302	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		4,800,302	30.00
31.00	Primary payer payments		221	31.00
32.00	Subtotal (line 30 minus line 31)		4,800,081	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)		343,149	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		223,047	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		269,046	36.00
37.00	Subtotal (see instructions)		5,023,128	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,023,128	40.00
40.01	Sequestration adjustment (see instructions)		100,463	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,720,916	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		201,749	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)		327	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/26/2019 9:23 am	
		Title XVIII	Hospital	PPS	
				Overrides	
				1.00	
WORKSHEET OVERRIDE VALUES					
112.00	Override of Ancillary service charges (line 12)				0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		621	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		621	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,760	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,760	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,760	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,139	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)		621	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			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)		49	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			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)		572	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)		572	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		572	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		572	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		572	40.00
40.01	Sequestration adjustment (see instructions)		11	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		392	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		169	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Skilled Nursing Facility	PPS
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/26/2019 9:23 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,286,071		4,720,916	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	06/05/2019	466,143		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)		466,143		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)		9,752,214		4,720,916	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		84,969		201,749	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		9,837,183		4,922,665	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0001
 Component CCN: 14-5572

 Period:
 From 07/01/2018
 To 06/30/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 11/26/2019 9:23 am

Title XVIII

 Skilled Nursing
 Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		929,736		392	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)		0		0	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)		929,736		392	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		405,945		169	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,335,681		561	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Hospital	PPS
			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
			Overrides	
			1.00	
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0001 Component CCN: 14-5572	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part VI Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Skilled Nursing Facility	PPS
			1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)		1,070,570	1.00
2.00	Routine service other pass through costs		401,642	2.00
3.00	Ancillary service other pass through costs		12,588	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,484,800	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		121,860	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,362,940	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,362,940	15.00
15.01	Sequestration adjustment (see instructions)		27,259	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		929,736	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		405,945	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet G

Date/Time Prepared:
11/26/2019 9:23 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	1,986,275	0	0	0	1.00
2.00 Temporary investments	12,199,696	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	32,034,253	0	0	0	4.00
5.00 Other receivable	4,262,797	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-19,263,294	0	0	0	6.00
7.00 Inventory	1,846,830	0	0	0	7.00
8.00 Prepaid expenses	1,700,920	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	34,767,477	0	0	0	11.00
FIXED ASSETS					
12.00 Land	3,145,860	0	0	0	12.00
13.00 Land improvements	2,606,977	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	97,031,180	0	0	0	15.00
16.00 Accumulated depreciation	-63,610,920	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	1,045,824	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	33,840,639	0	0	0	23.00
24.00 Accumulated depreciation	0	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	529,314	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	74,588,874	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	83,382,605	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	2,355,487	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	85,738,092	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	195,094,443	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	4,495,792	0	0	0	37.00
38.00 Salaries, wages, and fees payable	4,284,560	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	2,440,687	0	0	0	43.00
44.00 Other current liabilities	1,522,515	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	12,743,554	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	42,694,585	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	6,606,218	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	49,300,803	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	62,044,357	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	133,050,086	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	133,050,086	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	195,094,443	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-1

Date/Time Prepared:
11/26/2019 9:23 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		132,042,467		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		909,393				2.00
3.00	Total (sum of line 1 and line 2)		132,951,860		0		3.00
4.00	CHANGE IN BENEFICIAL INTEREST IN PER	55,559		0		0	4.00
5.00	CHANGE IN TEMPORARILY RESTRICTED NET	42,667		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)		98,226		0		10.00
11.00	Subtotal (line 3 plus line 10)		133,050,086		0		11.00
12.00	CHANGE IN TEMPORARILY RESTRICTED NET	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)		133,050,086		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	CHANGE IN BENEFICIAL INTEREST IN PER		0				4.00
5.00	CHANGE IN TEMPORARILY RESTRICTED NET		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	CHANGE IN TEMPORARILY RESTRICTED NET		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2019 9:23 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,814,644		11,814,644	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	1,975,104		1,975,104	7.00
8.00	NURSING FACILITY	1,054,435		1,054,435	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,844,183		14,844,183	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,122,364		2,122,364	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)	2,122,364		2,122,364	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	16,966,547		16,966,547	17.00
18.00	Ancillary services	39,755,142	127,413,381	167,168,523	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	19,869,019	19,869,019	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	DURABLE MEDICAL EQUIP - RENTED	0	4,178,273	4,178,273	27.00
27.01	PROFESSIONAL FEES	1,633,872	8,433,066	10,066,938	27.01
27.02	LAB GROSS UP	0	-471,248	-471,248	27.02
27.03	SCHOOL OF NURSING	0	450,335	450,335	27.03
27.04	DIETARY	0	669,192	669,192	27.04
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	58,355,561	160,542,018	218,897,579	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		88,556,030		29.00
30.00	PROVISION FOR BAD DEBTS	10,580,031			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)		10,580,031		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)		99,136,061		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0001

Period:
From 07/01/2018
To 06/30/2019

Worksheet G-3

Date/Time Prepared:
11/26/2019 9:23 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	218,897,579	1.00
2.00	Less contractual allowances and discounts on patients' accounts	129,130,693	2.00
3.00	Net patient revenues (line 1 minus line 2)	89,766,886	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	99,136,061	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,369,175	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	51,461	6.00
7.00	Income from investments	4,639,899	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	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	13,182	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,018,702	24.00
24.01	340B RETAIL PHARMACY	6,026,919	24.01
24.02	OTHER (SPECIFY)	0	24.02
24.03	OTHER (SPECIFY)	0	24.03
25.00	Total other income (sum of lines 6-24)	11,750,163	25.00
26.00	Total (line 5 plus line 25)	2,380,988	26.00
27.00	CHANGE IN FV OF INTEREST RATE SWAP	1,019,648	27.00
27.01	LOSS ON DISPOSAL	451,947	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	1,471,595	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	909,393	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0001	Period: From 07/01/2018 To 06/30/2019	Worksheet L Parts I-III Date/Time Prepared: 11/26/2019 9:23 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		488,741	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,777	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		19.28	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		490,518	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-3493

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 9:23 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	467,737	0	467,737	0	467,737 1.00
2.00	Physician Assistant	440,396	0	440,396	0	440,396 2.00
3.00	Nurse Practitioner	725,924	0	725,924	-82,454	643,470 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	1,906,672	0	1,906,672	-111,660	1,795,012 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	216,700	0	216,700	0	216,700 9.00
10.00	Subtotal (sum of lines 1 through 9)	3,757,429	0	3,757,429	-194,114	3,563,315 10.00
11.00	Physician Services Under Agreement	0	9,675,819	9,675,819	-2,297,039	7,378,780 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	9,675,819	9,675,819	-2,297,039	7,378,780 14.00
15.00	Medical Supplies	0	160,339	160,339	0	160,339 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	23,970	23,970	0	23,970 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	184,309	184,309	0	184,309 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,757,429	9,860,128	13,617,557	-2,491,153	11,126,404 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	5,134	5,134	0	5,134 29.00
30.00	Administrative Costs	1,419,124	115,868	1,534,992	-6,045	1,528,947 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,419,124	121,002	1,540,126	-6,045	1,534,081 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,176,553	9,981,130	15,157,683	-2,497,198	12,660,485 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-0001

Period:

Worksheet M-1

Component CCN: 14-3493

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 9:23 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	467,737	1.00
2.00	Physician Assistant	0	440,396	2.00
3.00	Nurse Practitioner	0	643,470	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	1,795,012	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	216,700	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,563,315	10.00
11.00	Physician Services Under Agreement	0	7,378,780	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	7,378,780	14.00
15.00	Medical Supplies	0	160,339	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	23,970	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	184,309	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	11,126,404	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	-8,649	-3,515	29.00
30.00	Administrative Costs	0	1,528,947	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-8,649	1,525,432	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,649	12,651,836	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-0001

Period:

Worksheet M-2

Component CCN: 14-3493

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/26/2019 9:23 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	13.69	58,752	4,200	57,498		1.00
2.00	Physician Assistant	3.42	11,847	2,100	7,182		2.00
3.00	Nurse Practitioner	7.77	16,550	2,100	16,317		3.00
4.00	Subtotal (sum of lines 1 through 3)	24.88	87,149		80,997	87,149	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)	24.88	87,149			87,149	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)					11,126,404	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					11,126,404	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,525,432	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					8,146,414	15.00
16.00	Total overhead (sum of lines 14 and 15)					9,671,846	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					9,671,846	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					9,671,846	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					20,798,250	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/26/2019 9:23 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)			20,798,250	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			668,452	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			20,129,798	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			87,149	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)			87,149	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			230.98	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)	230.98	230.98	9.00	
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	17,301	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	3,996,185	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	3,996,185	16.00	
16.01	Total program charges (see instructions)(from contractor's records)		2,519,977	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)		145,318	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		230,444	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.)		2,822,340	16.04	
16.05	Total program cost (see instructions)	0	3,052,784	16.05	
17.00	Primary payer amounts		0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		237,816	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		427,345	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)		3,052,784	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		156,096	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)		3,208,880	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)		3,208,880	26.00	
26.01	Sequestration adjustment (see instructions)		64,178	26.01	
26.02	Demonstration payment adjustment amount after sequestration		0	26.02	
27.00	Interim payments		2,460,827	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)		683,875	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00	

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/26/2019 9:23 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)		3,563,315	3,563,315	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000612	0.001097	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,181	3,909	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		301,036	50,473	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		303,217	54,382	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		11,126,404	11,126,404	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		9,671,846	9,671,846	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.027252	0.004888	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		263,577	47,276	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		566,794	101,658	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		1,891	3,392	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		299.73	29.97	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		428	928	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		128,284	27,812	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)			668,452	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)			156,096	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-0001 Component CCN: 14-3493	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/26/2019 9:23 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		2,310,590	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01		06/05/2019	150,237		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)		150,237		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,460,827		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		683,875		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		3,144,702		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00		
		1.00	2.00		
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00