

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: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet S Parts I-III Date/Time Prepared: 1/30/2020 9:52 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 1/30/2020	Time: 9:52 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by THOMAS H BOYD CRITICAL ACC HOSPITAL (14-1300) for the cost reporting period beginning 09/01/2018 and ending 08/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) DEBORAH CAMPBELL
Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	35,819	-103,360	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	8,579	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		45,847		0	10.00
200.00	Total	0	44,398	-57,513	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: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet S-2 Part I Date/Time Prepared: 1/30/2020 9:52 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 800 SCHOOL STREET			PO Box:				1.00				
2.00	City: CARROLLTON			State: IL		Zip Code: 62016		County: GREENE				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			THOMAS H BOYD CRITICAL ACC HOSPITAL	141300	99914	1	07/12/1999	N	O	N	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF			THOMAS H BOYD CRITICAL ACC SWING BED	14Z300	99914		07/12/1999	N	O	N	7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC			GREENE COUNTY RHC	143403	99914		06/22/1995	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						09/01/2018	08/31/2019		20.00		
21.00	Type of Control (see instructions)						2			21.00		
							1.00	2.00		3.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickles amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	24.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part I
Date/Time Prepared:
1/30/2020 9:52 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	48.00
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)				N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part I
Date/Time Prepared:
1/30/2020 9:52 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part I
Date/Time Prepared:
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part I Date/Time Prepared: 1/30/2020 9:52 am				
				1.00				
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.06		
Rural Providers								
105.00	Does this hospital qualify as a CAH?			Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	Y	Y	N	109.00
						1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part I Date/Time Prepared: 1/30/2020 9:52 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:	82,310	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet S-2 Part I Date/Time Prepared: 1/30/2020 9:52 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:					
142.00	Street:	PO Box:							
143.00	City:	State:		Zip Code:					
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?								Y
								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
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	Y	Y	N	N	155.00			
156.00	Subprovider - IPF	N	N	N	N	156.00			
157.00	Subprovider - IRF	N	N	N	N	157.00			
158.00	SUBPROVIDER					158.00			
159.00	SNF	N	N	N	N	159.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00			
161.00	CMHC		N	N	N	161.00			
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N
		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
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00
						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)						10/01/2018	12/31/2018	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: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part II Date/Time Prepared: 1/30/2020 9:52 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	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/12/2019	Y 12/12/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet S-2 Part II Date/Time Prepared: 1/30/2020 9:52 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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		Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y	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.		Y	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.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet S-2
Part II
Date/Time Prepared:
1/30/2020 9:52 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.	DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/30/2020 9:52 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	7,889.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	7,889.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	7,889.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/30/2020 9:52 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)	238	13	365			1.00
2.00	HMO and other (see instructions)	42	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	377	0	490			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	50			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	615	13	905			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)	615	13	905	0.00	114.06	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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)	3,607	0	13,693	0.00	15.19	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	129.25	27.00
28.00	Observation Bed Days		0	93			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet S-3
Part I
Date/Time Prepared:
1/30/2020 9:52 am

Component		Full Time Equivalents	Discharges			17.00/2025 0.00	am
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	82	4	130	1.00
2.00	HMO and other (see instructions)			11	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	82	4	130	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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

Health Financial Systems		THOMAS H BOYD CRITICAL ACC HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1300 Component CCN: 14-3403		Period: From 09/01/2018 To 08/31/2019 Worksheet S-8 Date/Time Prepared: 1/30/2020 9:52 am		
		RHC I		Cost		
		1.00				
1.00	Clinic Address and Identification					1.00
	Street	800 SCHOOL STREET				1.00
		City	State	ZIP Code		
		1.00	2.00	3.00		
2.00	City, State, ZIP Code, County	CARROLLTON		IL 62016	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		
4.00	Source of Federal Funds					4.00
5.00	Community Health Center (Section 330(d), PHS Act)					5.00
6.00	Migrant Health Center (Section 329(d), PHS Act)					6.00
7.00	Health Services for the Homeless (Section 340(d), PHS Act)					7.00
8.00	Appalachian Regional Commission					8.00
9.00	Look-Alikes					9.00
9.00	OTHER (SPECIFY)					9.00
		1.00		2.00		
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00	
		Sunday		Monday	Tuesday	
		from	to	from	to	
		1.00	2.00	3.00	4.00	
		1.00		2.00		
11.00	Facility hours of operations (1)					11.00
	CLINIC	08:00	16:00	07:00	19:00	
		1.00		2.00		
12.00	Have you received an approval for an exception to the productivity standard?	Y		4	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.				13.00	
		Provider name		CCN number		
		1.00		2.00		
14.00	RHC/FQHC name, CCN number	GREENE COUNTY RURAL HEALTHC CLINIC		143403	14.00	
14.01		THOMAS H BOYD RURAL HEALTH CLINIC		143475	14.01	
14.02		BOYD-FILLAGER CLINIC - GREENFIELD		143474	14.02	
14.03		RURAL HEALTH CENTER OF ROODHOUSE		143476	14.03	
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
		1.00		2.00		
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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1300

Period:

Worksheet S-8

Component CCN: 14-3403

From 09/01/2018
To 08/31/2019Date/Time Prepared:
1/30/2020 9:52 am

						RHC I		Cost		
				County						
				4.00						
2.00	City, State, ZIP Code, County			GREENE COUNTY					2.00	
				Tuesday		Wednesday		Thursday		
				to		from to		from to		
				6.00		7.00 8.00		9.00 10.00		
11.00	Facility hours of operations (1)									
	CLINIC			19:00	07:00	19:00	07:00	19:00		
				Friday		Saturday				
				from to		from to				
				11.00 12.00		13.00 14.00				
11.00	Facility hours of operations (1)									
	CLINIC			07:00	19:00	08:00	16:00		11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet S-10 Date/Time Prepared: 1/30/2020 9:52 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)		0.601748	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,263,709	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	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		0	5.00	
6.00	Medicaid charges		3,560,624	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,142,598	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	27,876	11,111	38,987	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	16,774	11,111	27,885	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)	16,774	11,111	27,885	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)		473,411	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		122,897	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		189,073	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		284,338	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		237,276	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		265,161	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		265,161	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/30/2020 9:52 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		164,419	164,419	-123,028	41,391	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.		0	0	18,023	18,023	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	218,351	218,351	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	698,609	698,609	194,246	892,855	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,068,577	963,254	2,031,831	222,484	2,254,315	5.00
7.00	00700	OPERATION OF PLANT	96,263	168,745	265,008	20,743	285,751	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,920	6,218	21,138	0	21,138	8.00
9.00	00900	HOUSEKEEPING	56,218	35,420	91,638	3,864	95,502	9.00
10.00	01000	DIETARY	165,211	51,262	216,473	0	216,473	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	66,382	8,539	74,921	0	74,921	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,941	55,845	83,786	0	83,786	14.00
15.00	01500	PHARMACY	0	238,292	238,292	0	238,292	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	80,829	9,084	89,913	0	89,913	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,074,160	229,654	1,303,814	-53,506	1,250,308	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	413,578	176,172	589,750	-17,498	572,252	54.00
60.00	06000	LABORATORY	390,524	384,189	774,713	1,501	776,214	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,114	11,114	1,127	12,241	63.00
64.00	06400	INTRAVENOUS THERAPY	405	0	405	0	405	64.00
66.00	06600	PHYSICAL THERAPY	302,934	81,737	384,671	0	384,671	66.00
69.00	06900	ELECTROCARDIOLOGY	0	24,080	24,080	17,314	41,394	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71,715	71,715	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,523,282	542,290	2,065,572	-434,490	1,631,082	88.00
90.00	09000	CLINIC	286,177	31,251	317,428	0	317,428	90.00
91.00	09100	EMERGENCY	1,196,006	617,364	1,813,370	-56,604	1,756,766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	496,955	162,837	659,792	-25,288	634,504	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		60,993	60,993	-60,993	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,260,362	4,721,368	11,981,730	-2,039	11,979,691	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07951	WELLNESS	59,776	1,421	61,197	2,039	63,236	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	7,320,138	4,722,789	12,042,927	0	12,042,927	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet A

Date/Time Prepared:
1/30/2020 9:52 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-5,472	35,919	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	18,023	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-23,344	195,007	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,274	887,581	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-252,773	2,001,542	5.00
7.00	00700	OPERATION OF PLANT	0	285,751	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,138	8.00
9.00	00900	HOUSEKEEPING	0	95,502	9.00
10.00	01000	DIETARY	-32,383	184,090	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	74,921	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	83,786	14.00
15.00	01500	PHARMACY	0	238,292	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,688	81,225	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-25,201	1,225,107	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	572,252	54.00
60.00	06000	LABORATORY	0	776,214	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	12,241	63.00
64.00	06400	INTRAVENOUS THERAPY	0	405	64.00
66.00	06600	PHYSICAL THERAPY	0	384,671	66.00
69.00	06900	ELECTROCARDIOLOGY	-24,080	17,314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71,715	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,631,082	88.00
90.00	09000	CLINIC	-217,562	99,866	90.00
91.00	09100	EMERGENCY	-229,712	1,527,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-353,521	280,983	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,178,010	10,801,681	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07951	WELLNESS	0	63,236	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,178,010	10,864,917	200.00

RECLASSIFICATIONS

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-6

Date/Time Prepared:
1/30/2020 9:52 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	5,730		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	129,467		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	2,000		3.00
	0		0	137,197		
	B - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	36,249		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	24,744		2.00
	0		0	60,993		
	C - EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	16,084	1,230		1.00
2.00		0.00	0	0		2.00
	0		16,084	1,230		
	D - RHC ADMIN COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	193,510		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	27,333		2.00
3.00	OPERATION OF PLANT	7.00	0	14,804		3.00
	0		0	235,647		
	E - RHC BUSINESS OFFICE AND HOUSEKEEPING					
1.00	ADMINISTRATIVE & GENERAL	5.00	197,556	12,706		1.00
2.00	HOUSEKEEPING	9.00	3,591	273		2.00
	0		201,147	12,979		
	F - RHC LAB TIME					
1.00	LABORATORY	60.00	2,428	200		1.00
2.00	BLOOD STORING, PROCESSING & TRANS.	63.00	1,050	77		2.00
	0		3,478	277		
	G - ER ADMIN TIME					
1.00	ADMINISTRATIVE & GENERAL	5.00	5,318	3,959		1.00
	0		5,318	3,959		
	H - LEASE EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	15,302		1.00
	0		0	15,302		
	I - PROPERTY TAXES					
1.00	CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	9,714		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	1,911		2.00
3.00	WELLNESS	194.00	0	2,775		3.00
	0		0	14,400		
	J - CONTINUING EDUCATION COSTS IN ER					
1.00	RURAL HEALTH CLINIC	88.00	0	14,000		1.00
	0		0	14,000		
	K - PROPERTY INSURANCE					
1.00	OTHER CAPITAL RELATED COSTS	3.00	0	54,081		1.00
2.00		0.00	0	0		2.00
	0		0	54,081		
	L - AMBULANCE OVERHEAD					
1.00	OPERATION OF PLANT	7.00	0	5,939		1.00
	0		0	5,939		
	M - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	71,715		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	71,715		
	N - WELLNESS CENTER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	693	43		1.00
	TOTALS		693	43		
500.00	Grand Total: Increases		226,720	627,762		500.00

RECLASSIFICATIONS

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet A-6
Date/Time Prepared:
1/30/2020 9:52 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	137,197	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
			0	137,197			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	60,993	11		1.00
2.00		0.00	0	0	0		2.00
			0	60,993			
	C - EKG SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	7,534	576	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	8,550	654	0		2.00
			16,084	1,230			
	D - RHC ADMIN COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	235,647	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
			0	235,647			
	E - RHC BUSINESS OFFICE AND HOUSEKEEPING						
1.00	RURAL HEALTH CLINIC	88.00	201,147	12,979	0		1.00
2.00		0.00	0	0	0		2.00
			201,147	12,979			
	F - RHC LAB TIME						
1.00	LABORATORY	60.00	1,050	77	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	2,428	200	0		2.00
			3,478	277			
	G - ER ADMIN TIME						
1.00	EMERGENCY	91.00	5,318	3,959	0		1.00
			5,318	3,959			
	H - LEASE EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	15,302	10		1.00
			0	15,302			
	I - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14,400	13		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
			0	14,400			
	J - CONTINUING EDUCATION COSTS IN ER						
1.00	EMERGENCY	91.00	0	14,000	0		1.00
			0	14,000			
	K - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,732	0		1.00
2.00	AMBULANCE SERVICES	95.00	0	19,349	0		2.00
			0	54,081			
	L - AMBULANCE OVERHEAD						
1.00	AMBULANCE SERVICES	95.00	0	5,939	0		1.00
			0	5,939			
	M - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	30,094	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,294	0		2.00
3.00	EMERGENCY	91.00	0	33,327	0		3.00
			0	71,715			
	N - WELLNESS CENTER						
1.00	WELLNESS	194.00	693	43	0		1.00
	TOTALS		693	43			
500.00	Grand Total: Decreases		226,720	627,762			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part I
Date/Time Prepared:
1/30/2020 9:52 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	70,514	0	0	0	0	1.00	
2.00	Land Improvements	49,823	0	0	0	36,143	2.00	
3.00	Buildings and Fixtures	1,402,662	0	0	0	1,155,359	3.00	
4.00	Building Improvements	1,188,414	0	0	0	950,690	4.00	
5.00	Fixed Equipment	84,028	0	0	0	74,716	5.00	
6.00	Movable Equipment	3,603,953	431,041	0	431,041	1,999,777	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	6,399,394	431,041	0	431,041	4,216,685	8.00	
9.00	Reconciling Items	-7,644	-1,600	0	-1,600	0	9.00	
10.00	Total (line 8 minus line 9)	6,407,038	432,641	0	432,641	4,216,685	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	70,514	0					1.00
2.00	Land Improvements	13,680	0					
3.00	Buildings and Fixtures	247,303	0					
4.00	Building Improvements	237,724	0					
5.00	Fixed Equipment	9,312	0					
6.00	Movable Equipment	2,035,217	0					
7.00	HIT designated Assets	0	0					
8.00	Subtotal (sum of lines 1-7)	2,613,750	0					
9.00	Reconciling Items	-9,244	0					
10.00	Total (line 8 minus line 9)	2,622,994	0					

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part II
Date/Time Prepared:
1/30/2020 9:52 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	164,419	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	164,419	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	NEW CAP REL COSTS-BLDG & FIXT	0	164,419				1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	164,419				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet A-7
Part III
Date/Time Prepared:
1/30/2020 9:52 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	NEW CAP REL COSTS-BLDG & FIXT	489,437	0	489,437	0.261988	14,169	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	89,096	0	89,096	0.047692	2,579	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,035,217	745,581	1,289,636	0.690320	37,333	2.00
3.00	Total (sum of lines 1-2)	2,613,750	745,581	1,868,169	1.000000	54,081	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	14,169	21,750	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	0	2,579	5,730	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	37,333	129,467	15,302	2.00
3.00	Total (sum of lines 1-2)	0	0	54,081	156,947	15,302	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	14,169	0	0	35,919	1.00
1.01	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	2,579	9,714	0	18,023	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	12,905	37,333	0	0	195,007	2.00
3.00	Total (sum of lines 1-2)	12,905	54,081	9,714	0	248,949	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/30/2020 9:52 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT NON HOSP. (chapter 2)			0 CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-23,344	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-14,331	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-4,259	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-478,993			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	-32,383	DIETARY	10.00	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	-4,252	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIXT NON HOSP.			0 CAP REL COSTS-BLDG & FIXT NON HOSP.	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0 NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0 *** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 *** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8

Date/Time Prepared:
1/30/2020 9:52 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	
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
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 HEALTHLINK FEES - HOSPITAL	A	12,771	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01 INTEREST EXPENSE - MEDICARE	A	-2,491	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 PHYSICIAN BENEFITS	A	-5,274	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
33.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.03
33.04 MISC INC - CPR CLASSES	B	-325	AMBULANCE SERVICES	95.00	0	33.04
33.05 MISC INC - CHART REVIEW	B	-4,436	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06 HEALTH FAIR	B	-9,301	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 IHA LOBBYING DUES	A	-4,034	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 AMBULANCE SUBSIDY - OPERATIONS	B	-353,196	AMBULANCE SERVICES	95.00	0	33.08
33.09 MEDICAID ASSESSMENT TAX	A	-187,396	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 GOODWILL AMORTIZATION	A	-5,472	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11 ENT RETAIL SALES	A	-17,562	CLINIC	90.00	0	33.11
33.12 340B EXPENSE	A	-41,736	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 VENDOR DEBT FORGIVENESS	A	-1,996	ADMINISTRATIVE & GENERAL	5.00	0	33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,178,010				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet A-8-2

Date/Time Prepared:
1/30/2020 9:52 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	25,201	25,201	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	24,080	24,080	0	0	0	2.00
3.00	90.00	CLINIC	200,000	200,000	0	0	0	3.00
4.00	91.00	EMERGENCY	1,172,600	229,712	942,888	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,421,881	478,993	942,888		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	25,201		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	24,080		2.00
3.00	90.00	CLINIC	0	0	0	200,000		3.00
4.00	91.00	EMERGENCY	0	0	0	229,712		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	478,993		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/30/2020 9:52 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					51	1.00
2.00	Line 1 multiplied by 15 hours per week					765	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					132	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.54	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	280.00	38.08	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.51	59.63	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.76	39.76	29.82			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					22,263	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					2,271	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					24,534	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					24,534	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					77.13	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					59,004	22.00
23.00	Total salary equivalency (see instructions)					59,004	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					5,248	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					5,248	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					731	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,979	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,979	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/30/2020 9:52 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.51	59.63	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					59,004	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					5,979	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					64,983	63.00
64.00	Total cost of outside supplier services (from your records)					25,382	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					5,248	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					731	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					5,979	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					731	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					731	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/30/2020 9:52 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					26	1.00
2.00	Line 1 multiplied by 15 hours per week					390	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					67	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.54	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	104.68	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.40	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.20	38.20	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					7,998	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					7,998	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					7,998	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					76.40	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					29,796	22.00
23.00	Total salary equivalency (see instructions)					29,796	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,559	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,559	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					371	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,930	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					2,930	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FORTHERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS				Provider CCN: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 1/30/2020 9:52 am	
						Speech Pathology		Cost	
								1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)							0	46.00
				Therapists	Assistants	Aides	Trainees	Total	
				1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.40	0.00	0.00	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	0	0	56.00
								1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							29,796	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							2,930	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							32,726	63.00
64.00	Total cost of outside supplier services (from your records)							6,281	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							2,559	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							371	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							2,930	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							371	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							371	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP	
			0	1.00	1.01	2.00	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	35,919	35,919			1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	18,023	0	18,023		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	195,007			195,007	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	887,581	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,001,542	4,596	2,201	32,133	5.00
7.00	00700	OPERATION OF PLANT	285,751	1,317	0	848	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,138	1,265	0	0	8.00
9.00	00900	HOUSEKEEPING	95,502	351	0	0	9.00
10.00	01000	DIETARY	184,090	3,730	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	74,921	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	83,786	709	0	0	14.00
15.00	01500	PHARMACY	238,292	486	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	81,225	691	0	350	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,225,107	11,236	0	33,185	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,252	1,645	0	93,312	54.00
60.00	06000	LABORATORY	776,214	970	0	12,992	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,241	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	405	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	384,671	2,160	0	18,576	66.00
69.00	06900	ELECTROCARDIOLOGY	17,314	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,715	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,631,082	2,085	0	0	88.00
90.00	09000	CLINIC	99,866	796	0	2,116	90.00
91.00	09100	EMERGENCY	1,527,054	3,343	0	1,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	280,983	539	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,801,681	35,919	2,201	195,007	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07951	WELLNESS	63,236	0	15,822	0	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,864,917	35,919	18,023	195,007	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

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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	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,202,654	2,202,654			5.00
7.00	00700	OPERATION OF PLANT	300,195	76,334	376,529		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,306	6,181	15,868	46,355	8.00
9.00	00900	HOUSEKEEPING	103,482	26,314	4,404	4,503	9.00
10.00	01000	DIETARY	208,894	53,118	46,804	455	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	83,388	21,204	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88,059	22,392	8,892	0	14.00
15.00	01500	PHARMACY	238,778	60,717	6,102	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	92,576	23,540	8,674	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,402,369	356,597	141,007	24,101	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	718,873	182,796	20,636	277	54.00
60.00	06000	LABORATORY	840,166	213,639	12,168	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,375	3,147	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	457	116	0	0	64.00
66.00	06600	PHYSICAL THERAPY	444,048	112,913	27,102	3,301	66.00
69.00	06900	ELECTROCARDIOLOGY	19,366	4,924	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,715	18,236	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,801,507	458,088	26,168	202	88.00
90.00	09000	CLINIC	113,770	28,930	9,984	0	90.00
91.00	09100	EMERGENCY	1,666,433	423,744	41,951	8,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	344,912	87,705	6,769	5,291	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,778,323	2,180,635	376,529	46,355	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07951	WELLNESS	86,594	22,019	0	0	194.00
200.00		Cross Foot Adjustments	0				200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,864,917	2,202,654	376,529	46,355	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1300

Period:
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Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	319,207					10.00
11.00	01100	CAFETERIA	251,314	251,314				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,043	107,635			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,270	0	122,613		14.00
15.00	01500	PHARMACY	0	0	0	0	305,597	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,896	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,893	63,137	75,040	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,855	0	0	0	54.00
60.00	06000	LABORATORY	0	26,129	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	65	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	32	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	15,250	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	939	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	122,613	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	305,597	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	19,362	0	0	0	88.00
90.00	09000	CLINIC	0	6,216	0	0	0	90.00
91.00	09100	EMERGENCY	0	41,443	32,595	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	40,569	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	319,207	248,206	107,635	122,613	305,597	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07951	WELLNESS	0	3,108	0	0	0	194.00
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)	319,207	251,314	107,635	122,613	305,597	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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	131,722				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,880	2,244,375	-52,437	2,191,938	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,617	967,134	0	967,134	54.00
60.00	06000	LABORATORY	18,552	1,119,939	0	1,119,939	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	15,587	0	15,587	63.00
64.00	06400	INTRAVENOUS THERAPY	0	605	627,700	628,305	64.00
66.00	06600	PHYSICAL THERAPY	2,946	605,596	0	605,596	66.00
69.00	06900	ELECTROCARDIOLOGY	0	25,229	0	25,229	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	212,564	0	212,564	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	305,597	0	305,597	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,314,721	0	2,314,721	88.00
90.00	09000	CLINIC	0	158,900	0	158,900	90.00
91.00	09100	EMERGENCY	56,989	2,282,508	-575,263	1,707,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	12,738	500,441	0	500,441	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,722	10,753,196	0	10,753,196	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07951	WELLNESS	0	111,721	0	111,721	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	131,722	10,864,917	0	10,864,917	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

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Cost Center Description			CAPITAL RELATED COSTS			Subtotal	
			NEW BLDG & FIXT	BLDG & FIXT NON HOSP.	NEW MVBLE EQUIP		
		Directly Assigned New Capital Related Costs					
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	4,596	2,201	32,133	38,930 5.00
7.00	00700	OPERATION OF PLANT	0	1,317	0	848	2,165 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,265	0	0	1,265 8.00
9.00	00900	HOUSEKEEPING	0	351	0	0	351 9.00
10.00	01000	DIETARY	0	3,730	0	0	3,730 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	709	0	0	709 14.00
15.00	01500	PHARMACY	0	486	0	0	486 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	691	0	350	1,041 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	11,236	0	33,185	44,421 30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,645	0	93,312	94,957 54.00
60.00	06000	LABORATORY	0	970	0	12,992	13,962 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00	06600	PHYSICAL THERAPY	0	2,160	0	18,576	20,736 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	17,686	2,085	0	0	19,771 88.00
90.00	09000	CLINIC	0	796	0	2,116	2,912 90.00
91.00	09100	EMERGENCY	0	3,343	0	1,495	4,838 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	539	0	0	539 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,686	35,919	2,201	195,007	250,813 118.00
NONREIMBURSABLE COST CENTERS							
194.00	07951	WELLNESS	0	0	15,822	0	15,822 194.00
200.00		Cross Foot Adjustments					0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	17,686	35,919	18,023	195,007	266,635 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	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	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	38,930				5.00
7.00	00700	OPERATION OF PLANT	0	1,349	3,514			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	109	148	1,522		8.00
9.00	00900	HOUSEKEEPING	0	465	41	148	1,005	9.00
10.00	01000	DIETARY	0	939	437	15	72	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	375	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	396	83	0	0	14.00
15.00	01500	PHARMACY	0	1,073	57	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	416	81	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,302	1,315	791	626	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,231	193	9	73	54.00
60.00	06000	LABORATORY	0	3,776	114	0	67	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	56	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	1,996	253	108	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	87	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	322	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	8,097	244	7	68	88.00
90.00	09000	CLINIC	0	511	93	0	0	90.00
91.00	09100	EMERGENCY	0	7,489	392	270	81	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,550	63	174	18	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	38,541	3,514	1,522	1,005	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07951	WELLNESS	0	389	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	38,930	3,514	1,522	1,005	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

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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	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	5,193					10.00
11.00	01100	CAFETERIA	4,088	4,088				11.00
13.00	01300	NURSING ADMINISTRATION	0	50	425			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	53	0	1,241		14.00
15.00	01500	PHARMACY	0	0	0	0	1,616	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	112	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,105	1,026	296	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	356	0	0	0	54.00
60.00	06000	LABORATORY	0	425	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	248	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	15	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,241	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,616	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	315	0	0	0	88.00
90.00	09000	CLINIC	0	101	0	0	0	90.00
91.00	09100	EMERGENCY	0	674	129	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	660	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,193	4,037	425	1,241	1,616	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07951	WELLNESS	0	51	0	0	0	194.00
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)	5,193	4,088	425	1,241	1,616	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1300

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
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	1,650				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	349	56,231	0	56,231	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	158	98,977	0	98,977	54.00
60.00	06000	LABORATORY	232	18,576	0	18,576	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	57	0	57	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3	0	3	64.00
66.00	06600	PHYSICAL THERAPY	37	23,378	0	23,378	66.00
69.00	06900	ELECTROCARDIOLOGY	0	102	0	102	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,563	0	1,563	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,616	0	1,616	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	28,502	0	28,502	88.00
90.00	09000	CLINIC	0	3,617	0	3,617	90.00
91.00	09100	EMERGENCY	714	14,587	0	14,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	160	3,164	0	3,164	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,650	250,373	0	250,373	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07951	WELLNESS	0	16,262	0	16,262	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,650	266,635	0	266,635	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			NEW BLDG & FIXT (SQUARE FEET)	BLDG & FIXT NON HOSP. (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	37,153					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.	0	7,074				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			157,674			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	6,958,308		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,754	864	25,981	1,271,451	-2,202,654	5.00
7.00	00700	OPERATION OF PLANT	1,362	0	686	96,263	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,308	0	0	14,920	0	8.00
9.00	00900	HOUSEKEEPING	363	0	0	59,809	0	9.00
10.00	01000	DIETARY	3,858	0	0	165,211	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	66,382	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	733	0	0	27,941	0	14.00
15.00	01500	PHARMACY	503	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	715	0	283	80,829	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,623	0	26,832	1,041,425	0	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,701	0	75,447	405,028	0	54.00
60.00	06000	LABORATORY	1,003	0	10,505	391,902	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,050	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	405	0	64.00
66.00	06600	PHYSICAL THERAPY	2,234	0	15,020	302,934	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	16,084	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,157	0	0	1,319,707	0	88.00
90.00	09000	CLINIC	823	0	1,711	86,177	0	90.00
91.00	09100	EMERGENCY	3,458	0	1,209	1,054,752	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	558	0	0	496,955	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,153	864	157,674	6,899,225	-2,202,654	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07951	WELLNESS	0	6,210	0	59,083	0	194.00
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)	35,919	18,023	195,007	887,581		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.966786	2.547781	1.236773	0.127557		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		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: 14-1300

Period:
From 09/01/2018
To 08/31/2019

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 (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,662,263				5.00
7.00	00700	OPERATION OF PLANT	300,195	31,037			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,306	1,308	34,870		8.00
9.00	00900	HOUSEKEEPING	103,482	363	3,387	57,585	9.00
10.00	01000	DIETARY	208,894	3,858	342	4,125	10.00
11.00	01100	CAFETERIA	0	0	0	12,815	11.00
13.00	01300	NURSING ADMINISTRATION	83,388	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	88,059	733	0	0	14.00
15.00	01500	PHARMACY	238,778	503	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	92,576	715	0	15	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,402,369	11,623	18,131	35,850	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	718,873	1,701	208	4,185	54.00
60.00	06000	LABORATORY	840,166	1,003	0	3,855	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,375	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	457	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	444,048	2,234	2,483	15	66.00
69.00	06900	ELECTROCARDIOLOGY	19,366	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71,715	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,801,507	2,157	152	3,900	88.00
90.00	09000	CLINIC	113,770	823	0	0	90.00
91.00	09100	EMERGENCY	1,666,433	3,458	6,187	4,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	344,912	558	3,980	1,020	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,575,669	31,037	34,870	57,585	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07951	WELLNESS	86,594	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,202,654	376,529	46,355	138,703	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.254282	12.131617	1.329366	2.408665	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	38,930	3,514	1,522	1,005	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004494	0.113220	0.043648	0.017452	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: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-1

Date/Time Prepared:
1/30/2020 9:52 am

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	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	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT NON HOSP.						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	7,762					11.00
13.00	01300	NURSING ADMINISTRATION	94	2,797				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	101	0	100			14.00
15.00	01500	PHARMACY	0	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	213	0	0	0	80,474	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,950	1,950	0	0	17,033	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	675	0	0	0	7,708	54.00
60.00	06000	LABORATORY	807	0	0	0	11,334	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	471	0	0	0	1,800	66.00
69.00	06900	ELECTROCARDIOLOGY	29	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	598	0	0	0	0	88.00
90.00	09000	CLINIC	192	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,280	847	0	0	34,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,253	0	0	0	7,782	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,666	2,797	100	100	80,474	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07951	WELLNESS	96	0	0	0	0	194.00
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)	251,314	107,635	122,613	305,597	131,722	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.377480	38.482302	1,226.130000	3,055.970000	1.636827	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,088	425	1,241	1,616	1,650	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.526668	0.151949	12.410000	16.160000	0.020504	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet B-2

Date/Time Prepared:
1/30/2020 9:52 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		IV THERAPY		1	30.00	-52,437
8.00		IV THERAPY		1	64.00	627,700
9.00		IV THERAPY		1	91.00	-575,263

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/30/2020 9:52 am

				Title XVIII	Hospital	Cost		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,191,938		2,191,938	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	967,134		967,134	0	0	54.00
60.00	06000	LABORATORY	1,119,939		1,119,939	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,587		15,587	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	628,305		628,305	0	0	64.00
66.00	06600	PHYSICAL THERAPY	605,596	0	605,596	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	25,229		25,229	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	212,564		212,564	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	305,597		305,597	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,314,721		2,314,721	0	0	88.00
90.00	09000	CLINIC	158,900		158,900	0	0	90.00
91.00	09100	EMERGENCY	1,707,245		1,707,245	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	214,261		214,261		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	500,441		500,441	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,967,457	0	10,967,457	0	0	200.00
201.00		Less Observation Beds	214,261		214,261			201.00
202.00		Total (see instructions)	10,753,196	0	10,753,196	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/30/2020 9:52 am

			Title XVIII		Hospital	Cost		
	Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	708,975		708,975			30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,440	4,143,468	4,267,908	0.226606	0.000000	54.00
60.00	06000	LABORATORY	162,893	3,863,282	4,026,175	0.278165	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,946	58,628	61,574	0.253143	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	7,541	565,148	572,689	1.097114	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	195,024	1,240,618	1,435,642	0.421829	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	6,884	359,113	365,997	0.068932	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	188,815	215,621	404,436	0.525581	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	299,921	439,415	739,336	0.413340	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,336,611	2,336,611			88.00
90.00	09000	CLINIC	0	203,747	203,747	0.779889	0.000000	90.00
91.00	09100	EMERGENCY	1,488	1,193,338	1,194,826	1.428865	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	126,807	126,807	1.689662	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,425,223	1,425,223	0.351132	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	1,698,927	16,171,019	17,869,946			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,698,927	16,171,019	17,869,946			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet C
Part I
Date/Time Prepared:
1/30/2020 9:52 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part II
Date/Time Prepared:
1/30/2020 9:52 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)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	98,977	4,267,908	0.023191	76,307	1,770	54.00
60.00	06000 LABORATORY	18,576	4,026,175	0.004614	77,073	356	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	57	61,574	0.000926	1,964	2	63.00
64.00	06400 INTRAVENOUS THERAPY	3	572,689	0.000005	0	0	64.00
66.00	06600 PHYSICAL THERAPY	23,378	1,435,642	0.016284	19,210	313	66.00
69.00	06900 ELECTROCARDIOLOGY	102	365,997	0.000279	2,442	1	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,563	404,436	0.003865	81,379	315	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,616	739,336	0.002186	111,018	243	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	28,502	2,336,611	0.012198	0	0	88.00
90.00	09000 CLINIC	3,617	203,747	0.017752	0	0	90.00
91.00	09100 EMERGENCY	14,587	1,194,826	0.012208	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,497	126,807	0.043349	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	196,475	15,735,748		369,393	3,000	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/30/2020 9:52 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part IV Date/Time Prepared: 1/30/2020 9:52 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	4,267,908	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,026,175	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	61,574	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	572,689	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,435,642	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	365,997	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	404,436	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	739,336	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,336,611	0.000000	88.00
90.00	09000	CLINIC	0	0	0	203,747	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,194,826	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	126,807	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	15,735,748		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part IV
Date/Time Prepared:
1/30/2020 9:52 am

Cost Center Description			Title XVIII		Hospital		Cost
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
			9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	76,307	0	0	0
60.00	06000	LABORATORY	0.000000	77,073	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	1,964	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	19,210	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,442	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	81,379	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	111,018	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
90.00	09000	CLINIC	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)		369,393	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet D
Part V
Date/Time Prepared:
1/30/2020 9:52 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226606	0	1,579,330	0	0	54.00	
60.00	06000	LABORATORY	0.278165	0	1,655,167	0	0	60.00	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.253143	0	49,799	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	1.097114	0	251,075	0	0	64.00	
66.00	06600	PHYSICAL THERAPY	0.421829	0	444,739	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.068932	0	174,540	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.525581	0	102,879	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413340	0	262,938	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
90.00	09000	CLINIC	0.779889	0	41,679	0	0	90.00	
91.00	09100	EMERGENCY	1.428865	0	391,375	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.689662	0	38,575	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.351132		0			95.00	
200.00		Subtotal (see instructions)		0	4,992,096	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	4,992,096	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-1300		Period: From 09/01/2018 To 08/31/2019		Worksheet D Part V Date/Time Prepared: 1/30/2020 9:52 am	
				Title XVIII		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	357,886	0					54.00
60.00	06000	LABORATORY	460,410	0					60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	12,606	0					63.00
64.00	06400	INTRAVENOUS THERAPY	275,458	0					64.00
66.00	06600	PHYSICAL THERAPY	187,604	0					66.00
69.00	06900	ELECTROCARDIOLOGY	12,031	0					69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,071	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	108,683	0					73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
90.00	09000	CLINIC	32,505	0					90.00
91.00	09100	EMERGENCY	559,222	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	65,179	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	2,125,655	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	2,125,655	0					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1300

Period:

From 09/01/2018

To 08/31/2019

Worksheet D

Part V

Date/Time Prepared:

1/30/2020 9:52 am

				Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.226606	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0.278165	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.253143	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1.097114	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.421829	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.068932	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.525581	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.413340	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000					0	88.00
90.00	09000	CLINIC	0.779889	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.428865	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.689662	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.351132		0				95.00
200.00		Subtotal (see instructions)		0	0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1300

Period:

Worksheet D

Component CCN: 14-Z300

From 09/01/2018
To 08/31/2019Part V
Date/Time Prepared:
1/30/2020 9:52 am

				Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet D-1 Date/Time Prepared: 1/30/2020 9:52 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			998	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			458	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)			365	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			207	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)			283	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			2	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)			48	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			238	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)			156	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)			221	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,191,938	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)			314	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)			7,545	25.00
26.00	Total swing-bed cost (see instructions)			1,136,760	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,055,178	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0	28.00
29.00	Private room charges (excluding swing-bed charges)			0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,055,178	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			2,303.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			548,323	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)			548,323	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/30/2020 9:52 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					136,158	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					684,481	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					359,405	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					509,157	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					868,562	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					93	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,303.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					214,261	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet D-1

Date/Time Prepared:
1/30/2020 9:52 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	56,231	2,191,938	0.025654	214,261	5,497	90.00
91.00	Nursing School cost	0	2,191,938	0.000000	214,261	0	91.00
92.00	Allied health cost	0	2,191,938	0.000000	214,261	0	92.00
93.00	All other Medical Education	0	2,191,938	0.000000	214,261	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet D-3 Date/Time Prepared: 1/30/2020 9:52 am	
		Title XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		295,172		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.226606	76,307	17,292	54.00
60.00	06000 LABORATORY	0.278165	77,073	21,439	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.253143	1,964	497	63.00
64.00	06400 INTRAVENOUS THERAPY	1.097114	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.421829	19,210	8,103	66.00
69.00	06900 ELECTROCARDIOLOGY	0.068932	2,442	168	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.525581	81,379	42,771	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.413340	111,018	45,888	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.779889	0	0	90.00
91.00	09100 EMERGENCY	1.428865	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.689662	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		369,393	136,158	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)		369,393		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1300 Component CCN: 14-Z300	Period: From 09/01/2018 To 08/31/2019	Worksheet D-3 Date/Time Prepared: 1/30/2020 9:52 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.226606	5,786	1,311	54.00
60.00	06000 LABORATORY	0.278165	31,062	8,640	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.253143	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	1.097114	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.421829	122,143	51,523	66.00
69.00	06900 ELECTROCARDIOLOGY	0.068932	3,341	230	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.525581	52,607	27,649	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.413340	101,301	41,872	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.779889	0	0	90.00
91.00	09100 EMERGENCY	1.428865	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.689662	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		316,240	131,225	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)		316,240		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet E Part B Date/Time Prepared: 1/30/2020 9:52 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,125,655	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,125,655	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,146,912	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		20,444	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		648,467	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,478,001	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,478,001	30.00
31.00	Primary payer payments		2,130	31.00
32.00	Subtotal (line 30 minus line 31)		1,475,871	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)		132,946	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		86,415	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		93,108	36.00
37.00	Subtotal (see instructions)		1,562,286	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,562,286	40.00
40.01	Sequestration adjustment (see instructions)		31,246	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,634,400	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-103,360	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet E-1
Part I
Date/Time Prepared:
1/30/2020 9:52 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		655,792		1,624,677	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0	08/29/2019	50,380	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	08/29/2019	68,535	02/27/2019	40,657	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)		-68,535		9,723	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)		587,257		1,634,400	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		35,819		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		103,360	6.02
7.00	Total Medicare program liability (see instructions)		623,076		1,531,040	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1300

Period:

Worksheet E-1

Component CCN: 14-Z300

From 09/01/2018
To 08/31/2019Part I
Date/Time Prepared:
1/30/2020 9:52 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,060,617		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	02/27/2019	12,838		0	3.50
3.51		08/29/2019	70,776		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)		-83,614		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)		977,003		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		8,579		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		985,582		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet E-1
Part II
Date/Time Prepared:
1/30/2020 9:52 am

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

Health Financial Systems		THOMAS H BOYD CRITICAL ACC HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet E-2	
		Component CCN: 14-Z300		Date/Time Prepared: 1/30/2020 9:52 am	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		877,248	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		132,537	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		377	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,009,785	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,009,785	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,009,785	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		4,089	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,005,696	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,005,696	0	19.00
19.01	Sequestration adjustment (see instructions)		20,114	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		977,003	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		8,579	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet E-3 Part V Date/Time Prepared: 1/30/2020 9:52 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		684,481	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		684,481	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		691,326	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		691,326	19.00
20.00	Deductibles (exclude professional component)		64,800	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		626,526	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		626,526	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		14,256	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		9,266	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		10,744	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		635,792	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		635,792	30.00
30.01	Sequestration adjustment (see instructions)		12,716	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		587,257	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		35,819	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet G

Date/Time Prepared:
1/30/2020 9:52 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	430,052	0	0	0	1.00
2.00	Temporary investments	177,785	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,308,109	0	0	0	4.00
5.00	Other receivable	61,817	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-701,919	0	0	0	6.00
7.00	Inventory	39,817	0	0	0	7.00
8.00	Prepaid expenses	36,060	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)	2,351,721	0	0	0	11.00
FIXED ASSETS						
12.00	Land	70,514	0	0	0	12.00
13.00	Land improvements	13,680	0	0	0	13.00
14.00	Accumulated depreciation	-912	0	0	0	14.00
15.00	Buildings	247,303	0	0	0	15.00
16.00	Accumulated depreciation	-161,041	0	0	0	16.00
17.00	Leasehold improvements	237,724	0	0	0	17.00
18.00	Accumulated depreciation	-181,920	0	0	0	18.00
19.00	Fixed equipment	9,312	0	0	0	19.00
20.00	Accumulated depreciation	-8,295	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	2,035,217	0	0	0	23.00
24.00	Accumulated depreciation	-1,261,692	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	9,244	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,009,134	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	27,358	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27,358	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	3,388,213	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,967,410	0	0	0	37.00
38.00	Salaries, wages, and fees payable	600,972	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	167,433	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	84,766	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,820,581	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	855,180	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	855,180	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,675,761	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-1,287,548	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)	-1,287,548	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	3,388,213	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet G-1

Date/Time Prepared:
1/30/2020 9:52 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		-1,071,676		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-215,872				2.00
3.00	Total (sum of line 1 and line 2)		-1,287,548		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-1,287,548		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-1,287,548		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
1/30/2020 9:52 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	459,894		459,894	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	226,018		226,018	5.00
6.00	Swing bed - NF	23,063		23,063	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	708,975		708,975	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	708,975		708,975	17.00
18.00	Ancillary services	988,464	10,885,293	11,873,757	18.00
19.00	Outpatient services	1,488	1,523,892	1,525,380	19.00
20.00	RURAL HEALTH CLINIC	0	2,336,611	2,336,611	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,425,223	1,425,223	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	155,861	801,370	957,231	27.00
27.01	CONTRACTED PT SERVICES & ENT SALES	0	96,886	96,886	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,854,788	17,069,275	18,924,063	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,042,927		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		12,042,927		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1300

Period:
From 09/01/2018
To 08/31/2019

Worksheet G-3

Date/Time Prepared:
1/30/2020 9:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	18,924,063	1.00
2.00	Less contractual allowances and discounts on patients' accounts	7,899,906	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,024,157	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,042,927	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,018,770	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	170,403	6.00
7.00	Income from investments	39,279	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	32,383	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	4,252	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	-2,522	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	13,600	22.00
23.00	Governmental appropriations	0	23.00
24.00	AMBULANCE SUBSIDY	353,196	24.00
24.01	WELLNESS CENTER INCOME	9,188	24.01
24.02	GRANT INCOME	41,999	24.02
24.03	340B INCOME	86,882	24.03
24.04	E.H.R. INCENTIVE INCOME	51,000	24.04
24.05	VENDOR DEBT FORGIVENESS	1,996	24.05
24.06	MISCELLANEOUS INCOME	15,665	24.06
25.00	Total other income (sum of lines 6-24)	817,321	25.00
26.00	Total (line 5 plus line 25)	-201,449	26.00
27.00	UNREALIZED LOSS ON INVESTMENTS	14,423	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	14,423	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-215,872	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1300

Period:

Worksheet M-1

Component CCN: 14-3403

From 09/01/2018
To 08/31/2019

Date/Time Prepared:

1/30/2020 9:52 am

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	482,832	38,226	521,058	0	521,058	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	536,647	42,487	579,134	0	579,134	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	303,140	24,000	327,140	0	327,140	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	23,223	1,839	25,062	0	25,062	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,345,842	106,552	1,452,394	0	1,452,394	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	60,626	60,626	0	60,626	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	242,842	242,842	-193,510	49,332	18.00
19.00	Other Health Care Costs	0	0	0	14,000	14,000	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	303,468	303,468	-179,510	123,958	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,345,842	410,020	1,755,862	-179,510	1,576,352	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	70,351	70,351	-10,893	59,458	29.00
30.00	Administrative Costs	177,440	61,919	239,359	-244,087	-4,728	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	177,440	132,270	309,710	-254,980	54,730	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,523,282	542,290	2,065,572	-434,490	1,631,082	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1300

Period:

Worksheet M-1

Component CCN: 14-3403

From 09/01/2018
To 08/31/2019Date/Time Prepared:
1/30/2020 9:52 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	521,058	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	579,134	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	327,140	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	25,062	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,452,394	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	60,626	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	49,332	18.00
19.00	Other Health Care Costs	0	14,000	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	123,958	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,576,352	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	59,458	29.00
30.00	Administrative Costs	0	-4,728	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	54,730	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,631,082	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1300

Period:

Worksheet M-2

Component CCN: 14-3403

From 09/01/2018
To 08/31/2019Date/Time Prepared:
1/30/2020 9:52 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.49	4,296	4,200	6,258		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.55	9,397	2,100	9,555		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.04	13,693		15,813	15,813	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)	6.04	13,693			15,813	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,576,352	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)					1,576,352	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					54,730	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					683,639	15.00
16.00	Total overhead (sum of lines 14 and 15)					738,369	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					738,369	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					738,369	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,314,721	20.00

Health Financial Systems		THOMAS H BOYD CRITICAL ACC HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1300	Period: From 09/01/2018 To 08/31/2019	Worksheet M-3	
		Component CCN: 14-3403		Date/Time Prepared: 1/30/2020 9:52 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)			2,314,721	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			36,480	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,278,241	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			15,813	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			15,813	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			144.07	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)		144.07	144.07	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	3,607	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	519,660	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	519,660	16.00
16.01	Total program charges (see instructions)(from contractor's records)			610,775	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			14,329	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			12,191	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.)			344,226	16.04
16.05	Total program cost (see instructions)		0	356,417	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			77,186	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			103,852	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			356,417	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			22,888	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			379,305	22.00
23.00	Allowable bad debts (see instructions)			41,871	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			27,216	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			27,118	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)			406,521	26.00
26.01	Sequestration adjustment (see instructions)			8,130	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			352,544	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)			45,847	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: 14-1300 Component CCN: 14-3403	Period: From 09/01/2018 To 08/31/2019	Worksheet M-4 Date/Time Prepared: 1/30/2020 9:52 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,452,394	1,452,394	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000321	0.001018	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		466	1,479	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		16,256	6,642	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		16,722	8,121	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,576,352	1,576,352	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		738,369	738,369	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010608	0.005152	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,833	3,804	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		24,555	11,925	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		118	374	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		208.09	31.89	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		87	150	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		18,104	4,784	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)			36,480	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)			22,888	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1300 Component CCN: 14-3403	Period: From 09/01/2018 To 08/31/2019	Worksheet M-5 Date/Time Prepared: 1/30/2020 9:52 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		333,503	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01		08/29/2019	19,041	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)		19,041	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		352,544	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		45,847	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		398,391	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00