

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: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/14/2019 8:03 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/14/2019	Time: 8:03 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 KIRBY HOSPITAL (14-1301) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KIMBERLY ALVIS

Officer or Administrator of Provider(s)

CHIEF FINANCIAL 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	191,492	216,628	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	153,485	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		11,322		0	10.00
10.01	RURAL HEALTH CLINIC II	0		100,619		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-51,836		0	10.02
200.00	Total	0	344,977	276,733	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: 14-1301		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/14/2019 8:03 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1000 MEDICAL CENTER DRIVE			PO Box:				1.00	
2.00	City: MONTICELLO			State: IL		Zip Code: 61856		County: PIATT 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		KIRBY HOSPITAL	141301	16580	1	08/08/1999	N	O
4.00	Subprovider - IPF								N
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		KIRBY HOSPITAL - SWING BED	142301	16580		08/08/1999	N	O
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O
15.01	Hospital-Based Health Clinic - RHC II		KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	N	O
15.02	Hospital-Based Health Clinic - RHC III		CERRO GORDO RURAL HEALTH CLINIC	148566	16580		12/29/2016	N	O
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/14/2019 8:03 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		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.					1		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: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					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 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1301		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/14/2019 8:03 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 07/01/2018
To 06/30/2019Worksheet S-2
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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		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			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
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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				1.00				
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				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.			Y		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			Y	N	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: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/14/2019 8:03 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:	144,998	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.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	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: 14-1301		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/14/2019 8:03 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:			Contractor's Number:			141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:			Zip Code:			143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		05/31/2019		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							Y	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					07/01/2018	09/30/2018		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: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/14/2019 8:03 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.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/01/2019	Y 10/01/2019
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: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/14/2019 8:03 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		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		Y		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.		Y		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.		Y		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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/14/2019 8:03 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, REIMBURSEMENT		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: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/14/2019 8:03 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	16	5,840	7,296.00	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)		16	5,840	7,296.00	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)		16	5,840	7,296.00	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 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		16				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: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/14/2019 8:03 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)	147	6	304			1.00
2.00	HMO and other (see instructions)	81	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	595	0	1,162			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	328			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	742	6	1,794			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)	742	6	1,794	0.00	181.55	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	RURAL HEALTH CLINIC	399	0	2,529	0.00	6.67	26.00
26.01	RURAL HEALTH CLINIC II	3,333	0	17,737	0.00	30.98	26.01
26.02	RURAL HEALTH CLINIC III	466	0	2,779	0.00	6.63	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	225.83	27.00
28.00	Observation Bed Days		0	191			28.00
29.00	Ambulance Trips	486					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: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/14/2019 8:03 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	50	3	134	1.00
2.00 HMO and other (see instructions)			23	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	50	3	134	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 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.02 RURAL HEALTH CLINIC III	0.00					26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1301 Component CCN: 14-3438		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/14/2019 8:03 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				108 SOUTH MAIN STREET				1.00
				City	State	ZIP Code			
				1.00	2.00	3.00			
2.00	City, State, ZIP Code, County				ATWOOD IL 61913				2.00
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0		3.00
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)								4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)								5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)								6.00
7.00	Appalachian Regional Commission								7.00
8.00	Look-Alikes								8.00
9.00	OTHER (SPECIFY)								9.00
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N		0		10.00
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC				08:00		16:30		11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				DOUGLAS				2.00
				Tuesday	Wednesday		Thursday		
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC				16:30		08:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-3438

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

Date/Time Prepared:

11/14/2019 8:03 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	08:00	16:30				11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1301 Component CCN: 14-3495		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/14/2019 8:03 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1000 MEDICAL CENTER DRIVE			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			MONTICELLO IL 61856		2.00			
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER (SPECIFY)							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		Monday		Tuesday	
				from	to	from	to	from	
				1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)									
11.00	CLINIC			07:00		18:00		07:00	
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				Y/N	V	XVIII	XIX	Total Visits	
				1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			PIATT				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			18:00		07:00		18:00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-3495

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

Date/Time Prepared:

11/14/2019 8:03 am

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	07:00	16:00	08:00	12:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301				Period: From 07/01/2018 To 06/30/2019		Worksheet S-8	
Component CCN: 14-8566				Date/Time Prepared: 11/14/2019 8:03 am			
RHC III				Cost			
				1.00			
1.00	Clinic Address and Identification Street			407 S. JACKSON STREET, SUITE A		1.00	
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			CERRO GORDO	IL	61818	2.00
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
				1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0	10.00
			Sunday		Monday		Tuesday
			from	to	from	to	from
			1.00	2.00	3.00	4.00	5.00
Facility hours of operations (1)							
11.00	CLINIC			07:00	17:30	07:00	11.00
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		0	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						14.00
			Y/N	V	XVIII	XIX	Total Visits
			1.00	2.00	3.00	4.00	5.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				County			
				4.00			
2.00	City, State, ZIP Code, County			PIATT		2.00	
			Tuesday	Wednesday		Thursday	
			to	from	to	from	to
			6.00	7.00	8.00	9.00	10.00
Facility hours of operations (1)							
11.00	CLINIC	16:30	08:00	17:30	08:00	16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1301

Period:

Worksheet S-8

Component CCN: 14-8566

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

Date/Time Prepared:

11/14/2019 8:03 am

RHC III

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	07:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet S-10 Date/Time Prepared: 11/14/2019 8:03 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)			0.392415 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	3,500,509		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	10,452,519		6.00
7.00	Medicaid cost (line 1 times line 6)	4,101,725		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)	601,216		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	9,929		9.00
10.00	Stand-alone CHIP charges	54,637		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	21,440		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	11,511		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)	612,727		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)	285,009	800,350	1,085,359 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	111,842	800,350	912,192 21.00
22.00	Payments received from patients for amounts previously written off as charity care	38,817	34,239	73,056 22.00
23.00	Cost of charity care (line 21 minus line 22)	73,025	766,111	839,136 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,125,796		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	261,150		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	401,768		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,724,028		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	817,152		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,656,288		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,269,015		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1301

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

Worksheet A

Date/Time Prepared:
11/14/2019 8:03 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	CAP REL COSTS-BLDG & FIXT		4,034,955	4,034,955	6,203	4,041,158	1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING		0	0	18,820	18,820	1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING		0	0	92,427	92,427	1.02
1.03	00103	CROSSFIT BUILDING		0	0	112,107	112,107	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,524,606	1,524,606	108,711	1,633,317	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	-9,050	-9,050	18,785	9,735	4.00
5.01	00540	PFS & REGISTRATION	459,129	463,688	922,817	451,713	1,374,530	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	2,431,524	4,906,431	7,337,955	-308,478	7,029,477	5.02
6.00	00600	MAINTENANCE & REPAIRS	282,305	299,094	581,399	0	581,399	6.00
7.00	00700	OPERATION OF PLANT	0	330,456	330,456	-52,892	277,564	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	51,219	51,219	8.00
9.00	00900	HOUSEKEEPING	302,538	163,123	465,661	0	465,661	9.00
10.00	01000	DIETARY	414,296	330,018	744,314	-642,395	101,919	10.00
11.00	01100	CAFETERIA	0	0	0	627,688	627,688	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,088	73,705	179,793	-12,258	167,535	14.00
15.00	01500	PHARMACY	197,826	561,247	759,073	-411,141	347,932	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	552,043	309,155	861,198	0	861,198	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	359,347	44,146	403,493	0	403,493	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,307,421	1,112,563	2,419,984	-48,086	2,371,898	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	551,072	2,002,480	2,553,552	-627,628	1,925,924	50.00
53.00	05300	ANESTHESIOLOGY	0	19,388	19,388	0	19,388	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	716,719	1,102,456	1,819,175	-6,050	1,813,125	54.00
56.00	03630	ULTRA SOUND	0	35,093	35,093	0	35,093	56.00
60.00	06000	LABORATORY	588,244	1,204,287	1,792,531	-1,732	1,790,799	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	578,891	283,210	862,101	-1,837	860,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,503	37,045	160,548	0	160,548	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,779	15,779	0	15,779	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,592	21,592	16,726	38,318	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	416,088	416,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	297,599	297,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	411,141	411,141	73.00
76.00	03950	SLEEP LAB	138,271	-11,204	127,067	-1,007	126,060	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	10,027	10,027	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	347,831	195,612	543,443	-75,208	468,235	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,654,738	1,176,632	3,831,370	-309,569	3,521,801	88.01
88.02	08802	RURAL HEALTH CLINIC III	361,386	169,939	531,325	-72,634	458,691	88.02
91.00	09100	EMERGENCY	1,090,867	2,842,882	3,933,749	-147,661	3,786,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	353,927	220,354	574,281	67,401	641,682	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,917,966	23,459,682	37,377,648	-11,921	37,365,727	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	61,495	51,572	113,067	0	113,067	190.01
190.02	19002	CROSSFIT	112,372	97,177	209,549	-5,314	204,235	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	17,235	17,235	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	14,091,833	23,608,431	37,700,264	0	37,700,264	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1301

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

Worksheet A

Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-138,333	3,902,825	1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING	0	18,820	1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	0	92,427	1.02
1.03	00103	CROSSFIT BUILDING	0	112,107	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-7,619	1,625,698	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,735	4.00
5.01	00540	PFS & REGISTRATION	-8	1,374,522	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	-1,424,151	5,605,326	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	581,399	6.00
7.00	00700	OPERATION OF PLANT	11,746	289,310	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,219	8.00
9.00	00900	HOUSEKEEPING	0	465,661	9.00
10.00	01000	DIETARY	-64	101,855	10.00
11.00	01100	CAFETERIA	-210,243	417,445	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-38	167,497	14.00
15.00	01500	PHARMACY	0	347,932	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-129	861,069	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	403,493	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-542,006	1,829,892	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-130,712	1,795,212	50.00
53.00	05300	ANESTHESIOLOGY	-6,450	12,938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-363,288	1,449,837	54.00
56.00	03630	ULTRA SOUND	0	35,093	56.00
60.00	06000	LABORATORY	0	1,790,799	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
66.00	06600	PHYSICAL THERAPY	-37,389	822,875	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	160,548	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,779	68.00
69.00	06900	ELECTROCARDIOLOGY	-21,286	17,032	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	416,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	297,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	411,141	73.00
76.00	03950	SLEEP LAB	77,977	204,037	76.00
76.01	03951	DIABETIC EDUCATION	0	10,027	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	468,235	88.00
88.01	08801	RURAL HEALTH CLINIC II	-847	3,520,954	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	458,691	88.02
91.00	09100	EMERGENCY	-1,084,046	2,702,042	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-58,032	583,650	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-3,934,918	33,430,809	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	FOUNDATION	0	113,067	190.01
190.02	19002	CROSSFIT	0	204,235	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	28,981	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,923,172	33,777,092	200.00

RECLASSIFICATIONS

Provider CCN: 14-1301

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

Worksheet A-6

Date/Time Prepared:
11/14/2019 8:03 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - PROPERTY INSURANCE					1.00
	OTHER CAP REL COSTS	3.00	0	98,263		
	0		0	98,263		
1.00	B - INTEREST RECLASS					1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	86,057		
	TOTALS		0	86,057		
1.00	C - CAFETERIA					1.00
	CAFETERIA	11.00	346,476	281,212		
	DIABETIC EDUCATION	76.01	8,228	1,799		
3.00	RURAL HEALTH CLINIC II	88.01	2,293	501	3.00	
	0		356,997	283,512		
1.00	D - EKG					1.00
	ELECTROCARDIOLOGY	69.00	13,236	3,490		
	0	0.00	0	0		
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	0		13,236	3,490		
1.00	E - RHC ADMITTING					1.00
	PFS & REGISTRATION	5.01	360,980	90,733		
	PHYSICIANS' PRIVATE OFFICES	192.00	4,214	1,034		
2.00		0.00	0	0	2.00	
3.00	0		365,194	91,767	3.00	
1.00	F - LAUNDRY					1.00
	LAUNDRY & LINEN SERVICE	8.00	0	51,219		
	0	0.00	0	0		
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
	0		0	51,219		
1.00	G - CROSSFIT EMPLOYEE BENEFITS					1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,708	1,798		
	0		2,708	1,798		
1.00	H - WORKERS' COMP INS					1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14,279		
	0		0	14,279		
1.00	I - TELEPHONE EXPENSE					1.00
	ADMINISTRATIVE & GENERAL	5.02	0	40,916		
	0	0.00	0	0		
2.00			0	40,916	2.00	
	0		0			
1.00	J - DOCTORS BLDG COSTS					1.00
	ADMINISTRATIVE & GENERAL	5.02	0	3,153		
	OPERATION OF PLANT	7.00	0	5,734		
2.00					2.00	
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,987	3.00	
	0		0	20,874		
1.00	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS					1.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	416,088		
	0					
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	297,599	2.00	
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	411,141	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
	TOTALS		0	1,124,828		
1.00	L - AMBULANCE SALARY					1.00
	AMBULANCE SERVICES	95.00	57,812	14,896		
	TOTALS		57,812	14,896		
1.00	N - DEPRECIATION EXPENSE RECLASS					1.00
	RURAL HEALTH CLINIC BUILDING	1.01	0	18,340		
	RURAL HEALTH CLINIC III BUILDING	1.02	0	90,048		
2.00					2.00	
3.00	CROSSFIT BUILDING	1.03	0	109,402	3.00	
	TOTALS		0	217,790		
1.00	O - BOND RELATED COSTS					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	153,948		
	TOTALS		0	153,948		
500.00	Grand Total: Increases		795,947	2,203,637	500.00	

RECLASSIFICATIONS

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet A-6
Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - PROPERTY INSURANCE						1.00
	ADMINISTRATIVE & GENERAL	5.02	0	98,263	12		
	0		0	98,263			
1.00	B - INTEREST RECLASS						1.00
	ADMINISTRATIVE & GENERAL	5.02	0	86,057	11		
	TOTALS		0	86,057			
1.00	C - CAFETERIA						1.00
	DIETARY	10.00	356,997	283,512	0		
	2.00	0.00	0	0	0		
3.00		0.00	0	0	0	3.00	
	0		356,997	283,512			
1.00	D - EKG						1.00
	LABORATORY	60.00	1,327	405	0		
	2.00	91.00	10,949	2,821	0		
3.00	RADIOLOGY-DIAGNOSTIC	54.00	960	264	0	3.00	
	0		13,236	3,490			
1.00	E - RHC ADMITTING						1.00
	RURAL HEALTH CLINIC	88.00	55,394	16,650	0		
	2.00	RURAL HEALTH CLINIC II	88.01	250,764	61,519	0	
3.00	RURAL HEALTH CLINIC III	88.02	59,036	13,598	0	3.00	
	0		365,194	91,767			
1.00	F - LAUNDRY						1.00
	DIETARY	10.00	0	1,886	0		
	2.00	ADULTS & PEDIATRICS	30.00	0	19,091	0	
3.00	OPERATING ROOM	50.00	0	9,326	0	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,826	0	4.00	
5.00	PHYSICAL THERAPY	66.00	0	1,837	0	5.00	
6.00	SLEEP LAB	76.00	0	1,007	0	6.00	
7.00	RURAL HEALTH CLINIC II	88.01	0	80	0	7.00	
8.00	EMERGENCY	91.00	0	11,911	0	8.00	
9.00	AMBULANCE SERVICES	95.00	0	447	0	9.00	
10.00	CROSSFIT	190.02	0	808	0	10.00	
	0		0	51,219			
1.00	G - CROSSFIT EMPLOYEE BENEFITS						1.00
	CROSSFIT	190.02	2,708	1,798	0		
	0		2,708	1,798			
1.00	H - WORKERS' COMP INS						1.00
	ADMINISTRATIVE & GENERAL	5.02	0	14,279	0		
	0		0	14,279			
1.00	I - TELEPHONE EXPENSE						1.00
	RURAL HEALTH CLINIC	88.00	0	3,164	0		
	2.00	OPERATION OF PLANT	7.00	0	37,752	0	
	0		0	40,916		2.00	
1.00	J - DOCTORS BLDG COSTS						1.00
	OPERATION OF PLANT	7.00	0	20,874	0		
	2.00		0.00	0	0		
3.00		0.00	0	0	0	3.00	
	0		0	20,874			
1.00	K - MEDICAL SUPPLIES, IMPLANTS & DRUGS						1.00
	CENTRAL SERVICES & SUPPLY	14.00	0	12,258	0		
	2.00	PHARMACY	15.00	0	411,141	0	
3.00	ADULTS & PEDIATRICS	30.00	0	28,995	0	3.00	
4.00	OPERATING ROOM	50.00	0	618,302	0	4.00	
5.00	EMERGENCY	91.00	0	49,272	0	5.00	
6.00	AMBULANCE SERVICES	95.00	0	4,860	0	6.00	
	TOTALS		0	1,124,828			
1.00	L - AMBULANCE SALARY						1.00
	EMERGENCY	91.00	57,812	14,896	0		
	TOTALS		57,812	14,896			
1.00	N - DEPRECIATION EXPENSE RECLASS						1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	217,790	9		
	2.00		0.00	0	9		
3.00		0.00	0	0	9	3.00	
	TOTALS		0	217,790			
1.00	O - BOND RELATED COSTS						1.00
	ADMINISTRATIVE & GENERAL	5.02	0	153,948	14		
	TOTALS		0	153,948			
500.00	Grand Total: Decreases		795,947	2,203,637		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/14/2019 8:03 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	389,780	0	0	0	0	1.00
2.00	Land Improvements	6,207,314	193,070	0	193,070	0	2.00
3.00	Buildings and Fixtures	22,292,501	1,468,715	0	1,468,715	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	13,460,648	1,567,596	0	1,567,596	0	5.00
6.00	Movable Equipment	8,773,565	1,711,730	0	1,711,730	549,089	6.00
7.00	HIT designated Assets	3,707,165	13,500	0	13,500	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,830,973	4,954,611	0	4,954,611	549,089	8.00
9.00	Reconciling Items	-1,011,828	-2,892,925	0	-2,892,925	-3,845,593	9.00
10.00	Total (line 8 minus line 9)	55,842,801	7,847,536	0	7,847,536	4,394,682	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	389,780	0				1.00
2.00	Land Improvements	6,400,384	0				2.00
3.00	Buildings and Fixtures	23,761,216	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	15,028,244	0				5.00
6.00	Movable Equipment	9,936,206	0				6.00
7.00	HIT designated Assets	3,720,665	0				7.00
8.00	Subtotal (sum of lines 1-7)	59,236,495	0				8.00
9.00	Reconciling Items	-59,160	0				9.00
10.00	Total (line 8 minus line 9)	59,295,655	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,472,494	0	1,562,461	0	0	1.00
1.01	RURAL HEALTH CLINIC BUILDING	0	0	0	0	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	0	0	0	1.02
1.03	CROSSFIT BUILDING	0	0	0	0	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	1,524,606	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,997,100	0	1,562,461	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	4,034,955				1.00
1.01	RURAL HEALTH CLINIC BUILDING	0	0				1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0				1.02
1.03	CROSSFIT BUILDING	0	0				1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,524,606				2.00
3.00	Total (sum of lines 1-2)	0	5,559,561				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	42,225,246	0	42,225,246	0.712825	70,045	1.00
1.01	RURAL HEALTH CLINIC BUILDING	289,068	0	289,068	0.004880	480	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	1,434,338	0	1,434,338	0.024214	2,379	1.02
1.03	CROSSFIT BUILDING	1,630,972	0	1,630,972	0.027533	2,705	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	13,656,871	0	13,656,871	0.230548	22,654	2.00
3.00	Total (sum of lines 1-2)	59,236,495	0	59,236,495	1.000000	98,263	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	70,045	2,254,704	0	1.00
1.01	RURAL HEALTH CLINIC BUILDING	0	0	480	18,340	0	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	0	2,379	90,048	0	1.02
1.03	CROSSFIT BUILDING	0	0	2,705	109,402	0	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	22,654	1,524,606	0	2.00
3.00	Total (sum of lines 1-2)	0	0	98,263	3,997,100	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,424,128	70,045	0	153,948	3,902,825	1.00
1.01	RURAL HEALTH CLINIC BUILDING	0	480	0	0	18,820	1.01
1.02	RURAL HEALTH CLINIC III BUILDING	0	2,379	0	0	92,427	1.02
1.03	CROSSFIT BUILDING	0	2,705	0	0	112,107	1.03
2.00	CAP REL COSTS-MVBLE EQUIP	78,438	22,654	0	0	1,625,698	2.00
3.00	Total (sum of lines 1-2)	1,502,566	98,263	0	153,948	5,751,877	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1301

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

Worksheet A-8

Date/Time Prepared:
11/14/2019 8:03 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	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-138,333	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - RURAL HEALTH CLINIC BUILDING (chapter 2)			RURAL HEALTH CLINIC BUILDING	1.01	0	1.01
1.02	Investment income - RURAL HEALTH CLINIC III BUILDING (chapter 2)			RURAL HEALTH CLINIC III BUILDING	1.02	0	1.02
1.03	Investment income - CROSSFIT BUILDING (chapter 2)			CROSSFIT BUILDING	1.03	0	1.03
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-7,619	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-1,663	ADMINISTRATIVE & GENERAL	5.02	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,069,774			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	-210,243	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-95	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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - RURAL HEALTH CLINIC BUILDING		0	RURAL HEALTH CLINIC BUILDING	1.01	0	26.01
26.02	Depreciation - RURAL HEALTH CLINIC III BUILDING		0	RURAL HEALTH CLINIC III BUILDING	1.02	0	26.02
26.03	Depreciation - CROSSFIT BUILDING		0	CROSSFIT BUILDING	1.03	0	26.03

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1301

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

Worksheet A-8

Date/Time Prepared:
11/14/2019 8:03 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	
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	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		0OCCUPATIONAL THERAPY	67.00		30.00
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		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	MISCELLANEOUS INCOME	B	-64,159	ADMINISTRATIVE & GENERAL	5.02	0	33.00
33.01	AMBULANCE INCOME	B	-58,032	AMBULANCE SERVICES	95.00	0	33.01
33.02	CANCER CLINIC INCOME	B	-13,443	ADMINISTRATIVE & GENERAL	5.02	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-37,331	PHYSICAL THERAPY	66.00	0	33.03
33.04	NON-ALLOWABLE ADVERTISING	A	-240,886	ADMINISTRATIVE & GENERAL	5.02	0	33.04
33.05	NON-ALLOWABLE LOBBYING	A	-10,532	ADMINISTRATIVE & GENERAL	5.02	0	33.05
33.06	PROPERTY TAX	A	-19,290	ADMINISTRATIVE & GENERAL	5.02	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-802,300	ADMINISTRATIVE & GENERAL	5.02	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-16,520	ADMINISTRATIVE & GENERAL	5.02	0	33.08
33.09	TRUST DEPR HOSPITAL ADMINISTRATION	A	6,459	ADMINISTRATIVE & GENERAL	5.02	0	33.09
33.10	TRUST DEPR OPERATION OF PLANT	A	11,746	OPERATION OF PLANT	7.00	0	33.10
33.11	TRUST DEPR PHYSICIAN PRIVATE OFFICES	A	11,746	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.11
33.12	TIF EXPENSE NOT RELATED TO THE HOSPI	A	-91,819	ADMINISTRATIVE & GENERAL	5.02	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.13
33.14	NON-ALLOWABLE DONATION EXPENSE	A	-169,830	ADMINISTRATIVE & GENERAL	5.02	0	33.14
33.15	KMG RHC MISC INCOME	B	-600	RURAL HEALTH CLINIC II	88.01	0	33.15
34.00	MISC EXPENSE - PFS & REGISTRATION	A	-8	PFS & REGISTRATION	5.01	0	34.00
34.01	MISC EXPENSE - A&G	A	-168	ADMINISTRATIVE & GENERAL	5.02	0	34.01
34.02	MISC EXPENSE - DIETARY	A	-64	DIETARY	10.00	0	34.02
34.03	MISC EXPENSE - CENTRAL SERVICES	A	-38	CENTRAL SERVICES & SUPPLY	14.00	0	34.03
34.04	MISC EXPENSE - MED RECORDS	A	-34	MEDICAL RECORDS & LIBRARY	16.00	0	34.04
34.05	MISC EXPENSE - OR	A	-12	OPERATING ROOM	50.00	0	34.05
34.06	MISC EXPENSE - PT	A	-58	PHYSICAL THERAPY	66.00	0	34.06
34.07	MISC EXPENSE - RHC II	A	-247	RURAL HEALTH CLINIC II	88.01	0	34.07
34.09	MISC EXPENSE - ANESESIA	A	-25	ANESTHESIOLOGY	53.00	0	34.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,923,172				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: 14-1301

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

Worksheet A-8-2

Date/Time Prepared:
11/14/2019 8:03 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	542,006	542,006	0	0	0	1.00
2.00	50.00	OPERATING ROOM	134,200	130,700	3,500	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	6,425	6,425	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	363,288	363,288	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	21,286	21,286	0	0	0	5.00
6.00	76.00	SLEEP LAB	-77,977	-77,977	0	0	0	6.00
7.00	91.00	EMERGENCY	2,361,663	1,084,046	1,277,617	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	15,000	0	15,000	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			3,365,891	2,069,774	1,296,117		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	76.00	SLEEP LAB	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	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	542,006		1.00
2.00	50.00	OPERATING ROOM	0	0	0	130,700		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	6,425		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	363,288		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	21,286		5.00
6.00	76.00	SLEEP LAB	0	0	0	-77,977		6.00
7.00	91.00	EMERGENCY	0	0	0	1,084,046		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	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	2,069,774		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1301		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/14/2019 8:03 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					13	1.00
2.00	Line 1 multiplied by 15 hours per week					195	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					52	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					5.63	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	510.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.61	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)	41.81	41.81	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)					42,641	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)					42,641	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)					42,641	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)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					42,641	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)					2,174	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)					2,174	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)					293	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,467	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)					2,467	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1301		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/14/2019 8:03 am		
		Physical Therapy				Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	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	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)	83.61	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	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	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	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)						42,641	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						2,467	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)						45,108	63.00
64.00	Total cost of outside supplier services (from your records)						37,440	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						2,174	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						293	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						2,467	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						293	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						293	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: 14-1301		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/14/2019 8:03 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					76	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					5.63	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	242.75	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.14	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)	38.07	38.07	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)					18,483	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)					18,483	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)					18,483	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)					76.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					59,389	22.00
23.00	Total salary equivalency (see instructions)					59,389	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)					2,893	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)					2,893	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)					428	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,321	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)					3,321	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1301		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/14/2019 8:03 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	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)	76.14	0.00	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						59,389	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						3,321	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)						62,710	63.00
64.00	Total cost of outside supplier services (from your records)						15,779	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						2,893	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						428	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						3,321	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						428	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						428	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	RURAL HEALTH CLINIC BUILDING	RURAL HEALTH CLINIC III BUILDING	CROSSFIT BUILDING	
		0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,902,825	3,902,825			1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING	18,820	0	18,820		1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	92,427	0	0	92,427	1.02
1.03	00103	CROSSFIT BUILDING	112,107	0	0	0	1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,625,698				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,735	0	0	0	4.00
5.01	00540	PFS & REGISTRATION	1,374,522	93,349	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	5,605,326	292,723	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	581,399	11,988	0	0	6.00
7.00	00700	OPERATION OF PLANT	289,310	804,914	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,219	15,132	0	0	8.00
9.00	00900	HOUSEKEEPING	465,661	41,417	0	0	9.00
10.00	01000	DIETARY	101,855	103,617	0	0	10.00
11.00	01100	CAFETERIA	417,445	55,371	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	167,497	80,428	0	0	14.00
15.00	01500	PHARMACY	347,932	27,857	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	861,069	74,188	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	403,493	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,829,892	431,616	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,795,212	360,426	0	0	50.00
53.00	05300	ANESTHESIOLOGY	12,938	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,449,837	166,800	0	0	54.00
56.00	03630	ULTRA SOUND	35,093	7,566	0	0	56.00
60.00	06000	LABORATORY	1,790,799	78,561	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	822,875	208,660	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	160,548	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,779	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	17,032	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	416,088	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	297,599	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	411,141	0	0	0	73.00
76.00	03950	SLEEP LAB	204,037	23,337	0	0	76.00
76.01	03951	DIABETIC EDUCATION	10,027	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	468,235	0	18,820	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,520,954	547,173	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	458,691	0	0	74,801	88.02
91.00	09100	EMERGENCY	2,702,042	308,003	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	583,650	153,043	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,430,809	3,886,169	18,820	74,801	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,939	0	0	190.00
190.01	19001	FOUNDATION	113,067	4,717	0	0	190.01
190.02	19002	CROSSFIT	204,235	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,981	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	17,626	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	33,777,092	3,902,825	18,820	92,427	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	PFS & REGISTRATION	Subtotal	ADMINISTRATIVE & GENERAL	
			MOVABLE EQUIP					
			2.00	4.00	5.01	5A.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,625,698					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,735				4.00
5.01	00540	PFS & REGISTRATION	0	567	1,468,438			5.01
5.02	00550	ADMINISTRATIVE & GENERAL	583,476	1,680	0	6,483,205	6,483,205	5.02
6.00	00600	MAINTENANCE & REPAIRS	21,014	195	0	614,596	145,987	6.00
7.00	00700	OPERATION OF PLANT	50,028	0	0	1,144,252	271,798	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	66,351	15,761	8.00
9.00	00900	HOUSEKEEPING	3,970	209	0	511,257	121,440	9.00
10.00	01000	DIETARY	35,032	41	0	240,545	57,137	10.00
11.00	01100	CAFETERIA	0	239	0	473,055	112,366	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,199	73	0	250,197	59,430	14.00
15.00	01500	PHARMACY	39,874	137	0	415,800	98,766	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,412	381	0	937,050	222,580	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	248	0	403,741	95,902	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,636	903	131,976	2,474,023	587,662	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	170,819	381	233,979	2,560,817	608,279	50.00
53.00	05300	ANESTHESIOLOGY	0	0	62,135	75,073	17,832	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	324,420	495	198,942	2,140,494	508,438	54.00
56.00	03630	ULTRA SOUND	61,629	0	21,037	125,325	29,769	56.00
60.00	06000	LABORATORY	57,441	406	271,937	2,199,144	522,369	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	10,937	400	73,001	1,115,873	265,057	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	85	7,985	168,618	40,052	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,394	17,173	4,079	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9	14,432	31,473	7,476	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	21,037	437,125	103,832	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	8,714	306,313	72,759	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	75,438	486,579	115,579	73.00
76.00	03950	SLEEP LAB	0	96	15,147	242,617	57,630	76.00
76.01	03951	DIABETIC EDUCATION	7,599	6	913	18,545	4,405	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,307	202	10,845	502,409	119,339	88.00
88.01	08801	RURAL HEALTH CLINIC II	22,381	1,661	73,517	4,165,686	989,493	88.01
88.02	08802	RURAL HEALTH CLINIC III	19,071	209	10,742	563,514	133,853	88.02
91.00	09100	EMERGENCY	20,790	706	192,976	3,224,517	765,929	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	102,205	285	42,291	881,474	209,379	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,618,240	9,614	1,468,438	33,276,841	6,364,378	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,939	2,836	190.00
190.01	19001	FOUNDATION		42	0	117,826	27,988	190.01
190.02	19002	CROSSFIT	7,458	76	0	323,876	76,931	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3	0	28,984	6,885	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	17,626	4,187	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,625,698	9,735	1,468,438	33,777,092	6,483,205	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1301

Period:
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Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS	760,583				6.00
7.00	00700	OPERATION OF PLANT	163,237	1,579,287			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,069	9,254	94,435		8.00
9.00	00900	HOUSEKEEPING	8,400	23,977	0	665,074	9.00
10.00	01000	DIETARY	21,014	63,369	3,477	23,014	10.00
11.00	01100	CAFETERIA	11,229	33,863	0	12,298	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,311	49,187	0	17,863	14.00
15.00	01500	PHARMACY	5,650	17,037	0	6,187	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,045	45,371	0	16,478	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	87,533	263,961	35,197	95,865	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	73,095	220,423	17,191	80,053	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,827	102,009	8,901	37,047	54.00
56.00	03630	ULTRA SOUND	1,534	4,627	0	1,680	56.00
60.00	06000	LABORATORY	15,932	48,045	0	17,449	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	42,317	127,609	3,387	46,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SLEEP LAB	4,733	14,272	1,857	5,183	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	6,168	0	0	6,755	88.00
88.01	08801	RURAL HEALTH CLINIC II	110,968	334,629	147	121,531	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	51,681	88.02
91.00	09100	EMERGENCY	62,464	188,363	21,963	68,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	31,037	23,106	824	8,392	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	713,563	1,569,102	92,944	616,230	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,421	7,301	0	0	190.00
190.01	19001	FOUNDATION	957	2,884	0	1,048	190.01
190.02	19002	CROSSFIT	43,642	0	1,491	47,796	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	760,583	1,579,287	94,435	665,074	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description		CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		11.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
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	642,811				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,700	406,688			14.00
15.00	01500	PHARMACY	9,897	2,521	555,858		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	61,868	1,767	0	1,300,159	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	105,892	10,001	0	247,550	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	43,634	14,188	0	172,401	0
53.00	05300	ANESTHESIOLOGY	5,363	1,741	0	0	499,643
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,090	8,412	0	68,388	0
56.00	03630	ULTRA SOUND	0	2,100	0	10,531	0
60.00	06000	LABORATORY	58,894	120,437	0	215,566	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	39,685	2,518	0	61,237	0
67.00	06700	OCCUPATIONAL THERAPY	7,801	45	0	3,120	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,080	0
69.00	06900	ELECTROCARDIOLOGY	829	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	89,902	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	64,300	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	555,858	0	0
76.00	03950	SLEEP LAB	8,971	2,199	0	4,161	0
76.01	03951	DIABETIC EDUCATION	683	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	10,412	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	108,425	52,515	0	60,457	0
88.02	08802	RURAL HEALTH CLINIC III	0	9,829	0	0	0
91.00	09100	EMERGENCY	91,851	9,685	0	422,164	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	18,185	2,045	0	32,504	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	632,768	404,617	555,858	1,300,159	499,643
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	FOUNDATION	2,633	0	0	0	0
190.02	19002	CROSSFIT	7,410	2,071	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	642,811	406,688	555,858	1,300,159	499,643

COST ALLOCATION - GENERAL SERVICE COSTS

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To 06/30/2019Worksheet B
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING				1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING				1.02
1.03	00103	CROSSFIT BUILDING				1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	PFS & REGISTRATION				5.01
5.02	00550	ADMINISTRATIVE & GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,316,240	-107,566	4,208,674	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,790,081	0	3,790,081	50.00
53.00	05300	ANESTHESIOLOGY	599,652	0	599,652	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,964,606	0	2,964,606	54.00
56.00	03630	ULTRA SOUND	175,566	0	175,566	56.00
60.00	06000	LABORATORY	3,197,836	0	3,197,836	60.00
64.00	06400	INTRAVENOUS THERAPY	0	107,566	107,566	64.00
66.00	06600	PHYSICAL THERAPY	1,704,028	0	1,704,028	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,636	0	219,636	67.00
68.00	06800	SPEECH PATHOLOGY	23,332	0	23,332	68.00
69.00	06900	ELECTROCARDIOLOGY	39,778	0	39,778	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	630,859	0	630,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	443,372	0	443,372	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,158,016	0	1,158,016	73.00
76.00	03950	SLEEP LAB	341,623	0	341,623	76.00
76.01	03951	DIABETIC EDUCATION	23,633	0	23,633	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	645,083	0	645,083	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,943,851	0	5,943,851	88.01
88.02	08802	RURAL HEALTH CLINIC III	758,877	0	758,877	88.02
91.00	09100	EMERGENCY	4,855,345	0	4,855,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,206,946	0	1,206,946	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,038,360	0	33,038,360	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,497	0	24,497	190.00
190.01	19001	FOUNDATION	153,336	0	153,336	190.01
190.02	19002	CROSSFIT	503,217	0	503,217	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,869	0	35,869	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	21,813	0	21,813	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)	33,777,092	0	33,777,092	202.00

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			CAPITAL RELATED COSTS					
Cost Center Description			Directly Assigned New Capital Related Costs	BLDG & FIXT	RURAL HEALTH CLINIC BUILDING	RURAL HEALTH CLINIC III BUILDING	CROSSFIT BUILDING	
			0	1.00	1.01	1.02	1.03	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	PFS & REGISTRATION	0	93,349	0	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	23,798	292,723	0	0	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	11,988	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	11,746	804,914	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,132	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	41,417	0	0	0	9.00
10.00	01000	DIETARY	0	103,617	0	0	0	10.00
11.00	01100	CAFETERIA	0	55,371	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,428	0	0	0	14.00
15.00	01500	PHARMACY	20,973	27,857	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,188	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,355	431,616	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	149,345	360,426	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	124,342	166,800	0	0	0	54.00
56.00	03630	ULTRA SOUND	0	7,566	0	0	0	56.00
60.00	06000	LABORATORY	0	78,561	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	208,660	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	1,156	23,337	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	18,820	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	547,173	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	74,801	0	88.02
91.00	09100	EMERGENCY	0	308,003	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	153,043	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		333,715	3,886,169	18,820	74,801	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,939	0	0	0	190.00
190.01	19001	FOUNDATION	0	4,717	0	0	0	190.01
190.02	19002	CROSSFIT	0	0	0	0	112,107	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,746	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	17,626	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	345,461	3,902,825	18,820	92,427	112,107	202.00

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Cost Center Description			CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	PFS & REGISTRATION	ADMINISTRATIVE & GENERAL	
			MVBLE EQUIP					
			2.00	2A	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00540	PFS & REGISTRATION	0	93,349	0	93,349		5.01
5.02	00550	ADMINISTRATIVE & GENERAL	583,476	899,997	0	0	899,997	5.02
6.00	00600	MAINTENANCE & REPAIRS	21,014	33,002	0	0	20,266	6.00
7.00	00700	OPERATION OF PLANT	50,028	866,688	0	0	37,731	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,132	0	0	2,188	8.00
9.00	00900	HOUSEKEEPING	3,970	45,387	0	0	16,858	9.00
10.00	01000	DIETARY	35,032	138,649	0	0	7,932	10.00
11.00	01100	CAFETERIA	0	55,371	0	0	15,599	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,199	82,627	0	0	8,250	14.00
15.00	01500	PHARMACY	39,874	88,704	0	0	13,711	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,412	75,600	0	0	30,898	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	13,313	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,636	513,607	0	8,392	81,578	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	170,819	680,590	0	14,878	84,440	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,951	2,475	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	324,420	615,562	0	12,650	70,581	54.00
56.00	03630	ULTRA SOUND	61,629	69,195	0	1,338	4,132	56.00
60.00	06000	LABORATORY	57,441	136,002	0	17,265	72,515	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	10,937	219,597	0	4,642	36,795	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	508	5,560	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	89	566	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	918	1,038	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,338	14,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	554	10,100	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,797	16,044	73.00
76.00	03950	SLEEP LAB	0	24,493	0	963	8,000	76.00
76.01	03951	DIABETIC EDUCATION	7,599	7,599	0	58	612	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,307	23,127	0	690	16,566	88.00
88.01	08801	RURAL HEALTH CLINIC II	22,381	569,554	0	4,675	137,368	88.01
88.02	08802	RURAL HEALTH CLINIC III	19,071	93,872	0	683	18,581	88.02
91.00	09100	EMERGENCY	20,790	328,793	0	12,271	106,325	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	102,205	255,248	0	2,689	29,066	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,618,240	5,931,745	0	93,349	883,502	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,939	0	0	394	190.00
190.01	19001	FOUNDATION		4,717	0	0	3,885	190.01
190.02	19002	CROSSFIT	7,458	119,565	0	0	10,679	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,746	0	0	956	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	17,626	0	0	581	194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,625,698	6,097,338	0	93,349	899,997	202.00

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Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS	53,268				6.00
7.00	00700	OPERATION OF PLANT	11,433	915,852			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	215	5,367	22,902		8.00
9.00	00900	HOUSEKEEPING	588	13,905	0	76,738	9.00
10.00	01000	DIETARY	1,472	36,748	843	2,655	10.00
11.00	01100	CAFETERIA	786	19,637	0	1,419	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,142	28,524	0	2,061	14.00
15.00	01500	PHARMACY	396	9,880	0	714	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,054	26,311	0	1,901	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,130	153,075	8,536	11,061	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,119	127,827	4,169	9,237	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,369	59,156	2,159	4,275	54.00
56.00	03630	ULTRA SOUND	107	2,683	0	194	56.00
60.00	06000	LABORATORY	1,116	27,862	0	2,013	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	2,964	74,002	821	5,347	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SLEEP LAB	331	8,277	450	598	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	432	0	0	779	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,772	194,057	36	14,024	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	5,963	88.02
91.00	09100	EMERGENCY	4,375	109,235	5,326	7,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,174	13,399	200	968	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,975	909,945	22,540	71,102	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	170	4,234	0	0	190.00
190.01	19001	FOUNDATION	67	1,673	0	121	190.01
190.02	19002	CROSSFIT	3,056	0	362	5,515	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	53,268	915,852	22,902	76,738	202.00

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Cost Center Description			CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			11.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	PFS & REGISTRATION						5.01
5.02	00550	ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	92,812					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,978	124,582				14.00
15.00	01500	PHARMACY	1,429	772	115,606			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,933	541	0	145,238		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	13,313	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,289	3,064	0	27,653		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,300	4,346	0	19,259		50.00
53.00	05300	ANESTHESIOLOGY	774	533	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,243	2,577	0	7,640		54.00
56.00	03630	ULTRA SOUND	0	643	0	1,176		56.00
60.00	06000	LABORATORY	8,503	36,895	0	24,080		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	5,730	771	0	6,841		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,126	14	0	349		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	232		68.00
69.00	06900	ELECTROCARDIOLOGY	120	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	27,540	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,697	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	115,606	0		73.00
76.00	03950	SLEEP LAB	1,295	674	0	465		76.00
76.01	03951	DIABETIC EDUCATION	99	0	0	0		76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,190	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	15,655	16,087	0	6,754		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	3,011	0	0		88.02
91.00	09100	EMERGENCY	13,262	2,967	0	47,158		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,626	626	0	3,631		95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	91,362	123,948	115,606	145,238	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	FOUNDATION	380	0	0	0		190.01
190.02	19002	CROSSFIT	1,070	634	0	0		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	0		194.00
200.00		Cross Foot Adjustments					13,313	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	92,812	124,582	115,606	145,238	13,313	202.00

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Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING				1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING				1.02
1.03	00103	CROSSFIT BUILDING				1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	PFS & REGISTRATION				5.01
5.02	00550	ADMINISTRATIVE & GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,016,684	0	1,016,684	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	956,165	0	956,165	50.00
53.00	05300	ANESTHESIOLOGY	7,733	0	7,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	785,212	0	785,212	54.00
56.00	03630	ULTRA SOUND	79,468	0	79,468	56.00
60.00	06000	LABORATORY	326,251	0	326,251	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	357,510	0	357,510	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,557	0	7,557	67.00
68.00	06800	SPEECH PATHOLOGY	887	0	887	68.00
69.00	06900	ELECTROCARDIOLOGY	2,076	0	2,076	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,292	0	43,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,351	0	30,351	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,447	0	136,447	73.00
76.00	03950	SLEEP LAB	45,546	0	45,546	76.00
76.01	03951	DIABETIC EDUCATION	8,368	0	8,368	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,784	0	44,784	88.00
88.01	08801	RURAL HEALTH CLINIC II	965,982	0	965,982	88.01
88.02	08802	RURAL HEALTH CLINIC III	122,110	0	122,110	88.02
91.00	09100	EMERGENCY	637,605	0	637,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	310,627	0	310,627	95.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,884,655	0	5,884,655	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,737	0	16,737	190.00
190.01	19001	FOUNDATION	10,843	0	10,843	190.01
190.02	19002	CROSSFIT	140,881	0	140,881	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,702	0	12,702	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	18,207	0	18,207	194.00
200.00		Cross Foot Adjustments	13,313	0	13,313	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,097,338	0	6,097,338	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1301

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

Worksheet B-1

Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description			CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	RURAL HEALTH CLINIC BUILDING (SQUARE FEET)	RURAL HEALTH CLINIC III BUILDING (SQUARE FEET)	CROSSFIT BUILDING (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	
			1.00	1.01	1.02	1.03	2.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,437					1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING	0	619				1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING	0	0	5,852			1.02
1.03	00103	CROSSFIT BUILDING	0	0	0	4,380		1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					1,603,044	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	PFS & REGISTRATION	1,900	0	0	0	0	5.01
5.02	00550	ADMINISTRATIVE & GENERAL	5,958	0	0	0	575,346	5.02
6.00	00600	MAINTENANCE & REPAIRS	244	0	0	0	20,721	6.00
7.00	00700	OPERATION OF PLANT	16,383	0	0	0	49,331	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	843	0	0	0	3,915	9.00
10.00	01000	DIETARY	2,109	0	0	0	34,544	10.00
11.00	01100	CAFETERIA	1,127	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,637	0	0	0	2,168	14.00
15.00	01500	PHARMACY	567	0	0	0	39,318	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510	0	0	0	1,392	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,785	0	0	0	78,526	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,336	0	0	0	168,439	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,395	0	0	0	319,899	54.00
56.00	03630	ULTRA SOUND	154	0	0	0	60,770	56.00
60.00	06000	LABORATORY	1,599	0	0	0	56,641	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,247	0	0	0	10,785	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	475	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	7,493	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	619	0	0	4,247	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,137	0	0	0	22,069	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	4,736	0	18,805	88.02
91.00	09100	EMERGENCY	6,269	0	0	0	20,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3,115	0	0	0	100,781	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,098	619	4,736	0	1,595,690	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	243	0	0	0	0	190.00
190.01	19001	FOUNDATION	96	0	0	0	0	190.01
190.02	19002	CROSSFIT	0	0	0	4,380	7,354	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	1,116	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)	3,902,825	18,820	92,427	112,107	1,625,698	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49.131072	30.403877	15.794087	25.595205	1.014132	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						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: 14-1301

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

Worksheet B-1

Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PFS & REGISTRATION (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			4.00	5.01	5A.02	5.02	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING						1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING						1.02
1.03	00103	CROSSFIT BUILDING						1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,089,154					4.00
5.01	00540	PFS & REGISTRATION	820,109	84,192,431				5.01
5.02	00550	ADMINISTRATIVE & GENERAL	2,431,524	0	-6,483,205	27,293,887		5.02
6.00	00600	MAINTENANCE & REPAIRS	282,305	0	0	614,596	76,334	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	1,144,252	16,383	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	66,351	308	8.00
9.00	00900	HOUSEKEEPING	302,538	0	0	511,257	843	9.00
10.00	01000	DIETARY	59,592	0	0	240,545	2,109	10.00
11.00	01100	CAFETERIA	346,476	0	0	473,055	1,127	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106,088	0	0	250,197	1,637	14.00
15.00	01500	PHARMACY	197,826	0	0	415,800	567	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	552,043	0	0	937,050	1,510	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	359,347	0	0	403,741	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,307,421	7,567,022	0	2,474,023	8,785	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	551,072	13,415,447	0	2,560,817	7,336	50.00
53.00	05300	ANESTHESIOLOGY	0	3,562,577	0	75,073	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	715,789	11,406,581	0	2,140,494	3,395	54.00
56.00	03630	ULTRA SOUND	0	1,206,176	0	125,325	154	56.00
60.00	06000	LABORATORY	586,917	15,589,758	0	2,199,144	1,599	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	578,891	4,185,614	0	1,115,873	4,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	123,503	457,803	0	168,618	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	79,917	0	17,173	0	68.00
69.00	06900	ELECTROCARDIOLOGY	13,235	827,466	0	31,473	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,206,171	0	437,125	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	499,601	0	306,313	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,325,340	0	486,579	0	73.00
76.00	03950	SLEEP LAB	138,271	868,445	0	242,617	475	76.00
76.01	03951	DIABETIC EDUCATION	8,228	52,362	0	18,545	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	292,437	621,806	0	502,409	619	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,403,974	4,215,155	0	4,165,686	11,137	88.01
88.02	08802	RURAL HEALTH CLINIC III	302,350	615,887	0	563,514	0	88.02
91.00	09100	EMERGENCY	1,022,106	11,064,514	0	3,224,517	6,269	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	411,739	2,424,789	0	881,474	3,115	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,913,781	84,192,431	-6,483,205	26,793,636	71,615	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,939	243	190.00
190.01	19001	FOUNDATION	61,495	0	0	117,826	96	190.01
190.02	19002	CROSSFIT	109,664	0	0	323,876	4,380	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,214	0	0	28,984	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	0	0	0	17,626	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)	9,735	1,468,438		6,483,205	760,583	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000691	0.017441		0.237533	9.963882	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	93,349		899,997	53,268	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.001109		0.032974	0.697828	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: 14-1301

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

Worksheet B-1

Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	52,561				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	308	81,618			8.00
9.00	00900	HOUSEKEEPING	798	0	60,947		9.00
10.00	01000	DIETARY	2,109	3,005	2,109	11,583	10.00
11.00	01100	CAFETERIA	1,127	0	1,127	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,637	0	1,637	0	14.00
15.00	01500	PHARMACY	567	0	567	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,510	0	1,510	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,785	30,420	8,785	11,583	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,336	14,858	7,336	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,395	7,693	3,395	0	54.00
56.00	03630	ULTRA SOUND	154	0	154	0	56.00
60.00	06000	LABORATORY	1,599	0	1,599	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	4,247	2,927	4,247	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	SLEEP LAB	475	1,605	475	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	619	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	11,137	127	11,137	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	4,736	0	88.02
91.00	09100	EMERGENCY	6,269	18,982	6,269	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	769	712	769	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,222	80,329	56,471	11,583	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	243	0	0	0	190.00
190.01	19001	FOUNDATION	96	0	96	0	190.01
190.02	19002	CROSSFIT	0	1,289	4,380	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	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)	1,579,287	94,435	665,074	408,556	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.046746	1.157036	10.912334	35.272037	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	915,852	22,902	76,738	188,299	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.424554	0.280600	1.259094	16.256497	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: 14-1301

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

Worksheet B-1

Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	RURAL HEALTH CLINIC BUILDING					1.01
1.02	00102	RURAL HEALTH CLINIC III BUILDING					1.02
1.03	00103	CROSSFIT BUILDING					1.03
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	PFS & REGISTRATION					5.01
5.02	00550	ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
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
14.00	01400	CENTRAL SERVICES & SUPPLY	1,882,257				14.00
15.00	01500	PHARMACY	11,669	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,180	0	10,000		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	46,286	0	1,904	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	65,668	0	1,326	0	50.00
53.00	05300	ANESTHESIOLOGY	8,060	0	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,931	0	526	0	54.00
56.00	03630	ULTRA SOUND	9,721	0	81	0	56.00
60.00	06000	LABORATORY	557,410	0	1,658	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	11,653	0	471	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	209	0	24	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	16	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	416,088	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	297,599	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	0	0	73.00
76.00	03950	SLEEP LAB	10,179	0	32	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	48,189	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	243,051	0	465	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	45,492	0	0	0	88.02
91.00	09100	EMERGENCY	44,825	0	3,247	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	9,463	0	250	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,872,673	100	10,000	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	190.01
190.02	19002	CROSSFIT	9,584	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CERRO GORDO RETAIL PHARMACY SPACE	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)	406,688	555,858	1,300,159	499,643	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.216064	5,558.580000	130.015900	4,996.430000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	124,582	115,606	145,238	13,313	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.066188	1,156.060000	14.523800	133.130000	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: 14-1301

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

Worksheet B-2

Date/Time Prepared:
11/14/2019 8:03 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 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		IV THERAPY		1	30.00	-107,566 7.00
8.00		IV THERAPY		1	64.00	107,566 8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/14/2019 8:03 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE	Total Costs	
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,208,674		4,208,674	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,790,081		3,790,081	0	0	50.00
53.00	05300	ANESTHESIOLOGY	599,652		599,652	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,964,606		2,964,606	0	0	54.00
56.00	03630	ULTRA SOUND	175,566		175,566	0	0	56.00
60.00	06000	LABORATORY	3,197,836		3,197,836	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	107,566		107,566	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,704,028	0	1,704,028	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,636	0	219,636	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,332	0	23,332	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,778		39,778	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	630,859		630,859	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	443,372		443,372	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,158,016		1,158,016	0	0	73.00
76.00	03950	SLEEP LAB	341,623		341,623	0	0	76.00
76.01	03951	DIABETIC EDUCATION	23,633		23,633	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	645,083		645,083	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,943,851		5,943,851	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	758,877		758,877	0	0	88.02
91.00	09100	EMERGENCY	4,855,345		4,855,345	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	479,185		479,185		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,206,946		1,206,946	0	0	95.00
200.00		Subtotal (see instructions)	33,517,545	0	33,517,545	0	0	200.00
201.00		Less Observation Beds	479,185		479,185		0	201.00
202.00		Total (see instructions)	33,038,360	0	33,038,360	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/14/2019 8:03 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,792,443		6,792,443		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	774,304	12,641,143	13,415,447	0.282516	0.000000
53.00	05300	ANESTHESIOLOGY	122,651	3,439,926	3,562,577	0.168320	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	160,746	11,245,835	11,406,581	0.259903	0.000000
56.00	03630	ULTRA SOUND	90,573	1,115,603	1,206,176	0.145556	0.000000
60.00	06000	LABORATORY	642,153	14,947,605	15,589,758	0.205124	0.000000
64.00	06400	INTRAVENOUS THERAPY	0	350,672	350,672	0.306742	0.000000
66.00	06600	PHYSICAL THERAPY	352,876	3,832,738	4,185,614	0.407115	0.000000
67.00	06700	OCCUPATIONAL THERAPY	280,994	176,809	457,803	0.479761	0.000000
68.00	06800	SPEECH PATHOLOGY	24,071	55,846	79,917	0.291953	0.000000
69.00	06900	ELECTROCARDIOLOGY	53,485	773,981	827,466	0.048072	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	251,578	954,593	1,206,171	0.523026	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155,159	344,442	499,601	0.887452	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1,198,412	3,126,928	4,325,340	0.267728	0.000000
76.00	03950	SLEEP LAB	0	868,445	868,445	0.393373	0.000000
76.01	03951	DIABETIC EDUCATION	0	52,362	52,362	0.451339	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	621,806	621,806		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,215,155	4,215,155		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	615,887	615,887		88.02
91.00	09100	EMERGENCY	23,774	11,040,740	11,064,514	0.438821	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	423,907	423,907	1.130401	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,424,789	2,424,789	0.497753	0.000000
200.00		Subtotal (see instructions)	10,923,219	73,269,212	84,192,431		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,923,219	73,269,212	84,192,431		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/14/2019 8:03 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					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	03630 ULTRA SOUND	0.000000			56.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03950 SLEEP LAB	0.000000			76.00
76.01	03951 DIABETIC EDUCATION	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
88.02	08802 RURAL HEALTH CLINIC III				88.02
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
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: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/14/2019 8:03 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							
50.00	05000 OPERATING ROOM	956,165	13,415,447	0.071273	317,630	22,638	50.00
53.00	05300 ANESTHESIOLOGY	7,733	3,562,577	0.002171	43,492	94	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	785,212	11,406,581	0.068839	33,700	2,320	54.00
56.00	03630 ULTRA SOUND	79,468	1,206,176	0.065884	31,902	2,102	56.00
60.00	06000 LABORATORY	326,251	15,589,758	0.020927	108,438	2,269	60.00
64.00	06400 INTRAVENOUS THERAPY	0	350,672	0.000000	0	0	64.00
66.00	06600 PHYSICAL THERAPY	357,510	4,185,614	0.085414	18,886	1,613	66.00
67.00	06700 OCCUPATIONAL THERAPY	7,557	457,803	0.016507	15,544	257	67.00
68.00	06800 SPEECH PATHOLOGY	887	79,917	0.011099	3,490	39	68.00
69.00	06900 ELECTROCARDIOLOGY	2,076	827,466	0.002509	22,739	57	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	43,292	1,206,171	0.035892	89,775	3,222	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	30,351	499,601	0.060750	81,860	4,973	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	136,447	4,325,340	0.031546	179,255	5,655	73.00
76.00	03950 SLEEP LAB	45,546	868,445	0.052445	0	0	76.00
76.01	03951 DIABETIC EDUCATION	8,368	52,362	0.159811	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	44,784	621,806	0.072022	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	965,982	4,215,155	0.229169	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	122,110	615,887	0.198267	0	0	88.02
91.00	09100 EMERGENCY	637,605	11,064,514	0.057626	365	21	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	115,756	423,907	0.273069	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	4,673,100	74,975,199		947,076	45,260	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	499,643	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
56.00	03630	ULTRA SOUND	0	0	0	0	0 56.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
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
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	SLEEP LAB	0	0	0	0	0 76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0 88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0 88.02
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)	499,643	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description		Title XVIII			Hospital	Cost	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	13,415,447	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	499,643	3,562,577	0.140248	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	11,406,581	0.000000	54.00
56.00	03630	ULTRA SOUND	0	0	1,206,176	0.000000	56.00
60.00	06000	LABORATORY	0	0	15,589,758	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	350,672	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	0	0	4,185,614	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	457,803	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	79,917	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	827,466	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,206,171	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	499,601	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,325,340	0.000000	73.00
76.00	03950	SLEEP LAB	0	0	868,445	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	52,362	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	621,806	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	4,215,155	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	615,887	0.000000	88.02
91.00	09100	EMERGENCY	0	0	11,064,514	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	423,907	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50 through 199)	0	499,643	0	74,975,199	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/14/2019 8:03 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							
50.00	05000	OPERATING ROOM	0.000000	317,630	0	0	0
53.00	05300	ANESTHESIOLOGY	0.000000	43,492	6,100	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	33,700	0	0	0
56.00	03630	ULTRA SOUND	0.000000	31,902	0	0	0
60.00	06000	LABORATORY	0.000000	108,438	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	18,886	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	15,544	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.000000	3,490	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.000000	22,739	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	89,775	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	81,860	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	179,255	0	0	0
76.00	03950	SLEEP LAB	0.000000	0	0	0	0
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0
88.02	08802	RURAL HEALTH CLINIC III	0.000000	0	0	0	0
91.00	09100	EMERGENCY	0.000000	365	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)		947,076	6,100	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/14/2019 8:03 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								
50.00	05000	OPERATING ROOM	0.282516	0	3,104,665	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.168320	0	864,998	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.259903	0	2,814,059	0	0	54.00	
56.00	03630	ULTRA SOUND	0.145556	0	283,600	0	0	56.00	
60.00	06000	LABORATORY	0.205124	0	3,913,316	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.306742	0	182,493	0	0	64.00	
66.00	06600	PHYSICAL THERAPY	0.407115	0	953,351	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.479761	0	51,598	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.291953	0	9,846	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.048072	0	249,382	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.523026	0	254,645	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.887452	0	75,134	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267728	0	1,682,240	39,185	0	73.00	
76.00	03950	SLEEP LAB	0.393373	0	170,519	0	0	76.00	
76.01	03951	DIABETIC EDUCATION	0.451339	0	4,422	0	0	76.01	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01	
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02	
91.00	09100	EMERGENCY	0.438821	0	2,451,712	21,951	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.130401	0	222,043	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.497753		0			95.00	
200.00		Subtotal (see instructions)		0	17,288,023	61,136	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	17,288,023	61,136	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/14/2019 8:03 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					
50.00	05000	OPERATING ROOM	877,118	0		50.00
53.00	05300	ANESTHESIOLOGY	145,596	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	731,382	0		54.00
56.00	03630	ULTRA SOUND	41,280	0		56.00
60.00	06000	LABORATORY	802,715	0		60.00
64.00	06400	INTRAVENOUS THERAPY	55,978	0		64.00
66.00	06600	PHYSICAL THERAPY	388,123	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	24,755	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,875	0		68.00
69.00	06900	ELECTROCARDIOLOGY	11,988	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,186	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	66,678	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	450,383	10,491		73.00
76.00	03950	SLEEP LAB	67,078	0		76.00
76.01	03951	DIABETIC EDUCATION	1,996	0		76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
91.00	09100	EMERGENCY	1,075,863	9,633		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	250,998	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,127,992	20,124		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,127,992	20,124		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301

Period:

Worksheet D

Component CCN: 14-Z301

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/14/2019 8:03 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							
50.00	05000	OPERATING ROOM	0.282516	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.168320	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.259903	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0.145556	0	0	0	0	56.00
60.00	06000	LABORATORY	0.205124	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.306742	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.407115	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.479761	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.291953	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048072	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.523026	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.887452	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267728	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.393373	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.451339	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
91.00	09100	EMERGENCY	0.438821	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.130401	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.497753		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1301

Period:

Worksheet D

Component CCN: 14-Z301

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/14/2019 8:03 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					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	03630	ULTRA SOUND	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	SLEEP LAB	0	0		76.00
76.01	03951	DIABETIC EDUCATION	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
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: 14-1301

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

Worksheet D-1

Date/Time Prepared:

11/14/2019 8:03 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)	1,985	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	495	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)	304	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	582	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)	580	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	145	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)	183	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	147	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)	266	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)	329	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)	4,208,674	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)	22,793	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)	28,766	25.00
26.00	Total swing-bed cost (see instructions)	2,966,808	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,241,866	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)	1,241,866	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)	2,508.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	368,797	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)	368,797	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1301

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

Worksheet D-1

Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)					317,715	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					686,512	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)					667,346	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					825,402	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,492,748	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)					191	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,508.82	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					479,185	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1301

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

Worksheet D-1

Date/Time Prepared:
11/14/2019 8:03 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,016,684	4,208,674	0.241569	479,185	115,756
91.00	Nursing School cost	0	4,208,674	0.000000	479,185	0
92.00	Allied health cost	0	4,208,674	0.000000	479,185	0
93.00	All other Medical Education	0	4,208,674	0.000000	479,185	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/14/2019 8:03 am	
Cost Center Description		Title XVIII	Hospital	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		623,052		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.282516	317,630	89,736	50.00
53.00	05300 ANESTHESIOLOGY	0.168320	43,492	7,321	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.259903	33,700	8,759	54.00
56.00	03630 ULTRA SOUND	0.145556	31,902	4,644	56.00
60.00	06000 LABORATORY	0.205124	108,438	22,243	60.00
64.00	06400 INTRAVENOUS THERAPY	0.306742	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.407115	18,886	7,689	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.479761	15,544	7,457	67.00
68.00	06800 SPEECH PATHOLOGY	0.291953	3,490	1,019	68.00
69.00	06900 ELECTROCARDIOLOGY	0.048072	22,739	1,093	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.523026	89,775	46,955	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.887452	81,860	72,647	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.267728	179,255	47,992	73.00
76.00	03950 SLEEP LAB	0.393373	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.451339	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100 EMERGENCY	0.438821	365	160	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.130401	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)		947,076	317,715	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)		947,076		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1301 Component CCN: 14-Z301	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/14/2019 8:03 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					
50.00	05000 OPERATING ROOM	0.282516	12,791	3,614	50.00
53.00	05300 ANESTHESIOLOGY	0.168320	6,932	1,167	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.259903	52,743	13,708	54.00
56.00	03630 ULTRA SOUND	0.145556	13,495	1,964	56.00
60.00	06000 LABORATORY	0.205124	210,073	43,091	60.00
64.00	06400 INTRAVENOUS THERAPY	0.306742	0	0	64.00
66.00	06600 PHYSICAL THERAPY	0.407115	142,240	57,908	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.479761	105,770	50,744	67.00
68.00	06800 SPEECH PATHOLOGY	0.291953	5,828	1,702	68.00
69.00	06900 ELECTROCARDIOLOGY	0.048072	3,448	166	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.523026	83,070	43,448	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.887452	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.267728	435,254	116,530	73.00
76.00	03950 SLEEP LAB	0.393373	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.451339	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
91.00	09100 EMERGENCY	0.438821	3,733	1,638	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.130401	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,075,377	335,680	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,075,377		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/14/2019 8:03 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,148,116	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)		5,148,116	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)		5,199,597	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)		25,322	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,640,031	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)		2,534,244	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)		2,534,244	30.00
31.00	Primary payer payments		196	31.00
32.00	Subtotal (line 30 minus line 31)		2,534,048	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		343,187	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		223,072	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		164,346	36.00
37.00	Subtotal (see instructions)		2,757,120	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,757,120	40.00
40.01	Sequestration adjustment (see instructions)		55,142	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,485,350	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		216,628	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: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/14/2019 8:03 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		404,275		2,392,050	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	01/28/2019	35,200	01/28/2019	93,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		35,200		93,300	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)		439,475		2,485,350	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		191,492		216,628	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		630,967		2,701,978	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: 14-1301

Period:

Worksheet E-1

Component CCN: 14-Z301

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/14/2019 8:03 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		1,641,480		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,641,480		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		153,485		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,794,965		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: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/14/2019 8:03 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1301

Period:

Worksheet E-2

Component CCN: 14-Z301

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,507,675	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)		339,037	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		595	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)		1,846,712	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,846,712	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)		1,846,712	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		15,115	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)		1,831,597	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)		1,831,597	0	19.00
19.01	Sequestration adjustment (see instructions)		36,632	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,641,480	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)		153,485	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: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/14/2019 8:03 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		686,512	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)		686,512	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		693,377	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)		693,377	19.00
20.00	Deductibles (exclude professional component)		58,148	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		635,229	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		635,229	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		13,254	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		8,615	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,235	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		643,844	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)		643,844	30.00
30.01	Sequestration adjustment (see instructions)		12,877	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		439,475	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)		191,492	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: 14-1301

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

Worksheet G

Date/Time Prepared:
11/14/2019 8:03 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	9,922,059	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	5,355,069	0	0	0	4.00
5.00 Other receivable	333,356	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	358,529	0	0	0	7.00
8.00 Prepaid expenses	1,149,538	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)	17,118,551	0	0	0	11.00
FIXED ASSETS					
12.00 Land	389,780	0	0	0	12.00
13.00 Land improvements	6,905,409	0	0	0	13.00
14.00 Accumulated depreciation	-2,491,191	0	0	0	14.00
15.00 Buildings	23,256,191	0	0	0	15.00
16.00 Accumulated depreciation	-7,499,255	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	15,028,244	0	0	0	19.00
20.00 Accumulated depreciation	-5,230,500	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	9,936,206	0	0	0	23.00
24.00 Accumulated depreciation	-5,210,860	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	3,720,665	0	0	0	27.00
28.00 Accumulated depreciation	-3,363,045	0	0	0	28.00
29.00 Minor equipment-nondepreciable	59,160	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	35,500,804	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	45,474,009	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	452,582	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	45,926,591	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	98,545,946	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,053,876	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,465,473	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	834,573	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	0	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	4,353,922	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	29,214,492	0	0	0	46.00
47.00 Notes payable	154,303	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)	29,368,795	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	33,722,717	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	64,823,229				52.00
53.00 Specific purpose fund		0			53.00
54.00 Donor created - endowment fund balance - restricted			0		54.00
55.00 Donor created - endowment fund balance - unrestricted			0		55.00
56.00 Governing body created - endowment fund balance			0		56.00
57.00 Plant fund balance - invested in plant				0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	64,823,229	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	98,545,946	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1301

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

Worksheet G-1

Date/Time Prepared:
11/14/2019 8:03 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		60,839,285		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,975,468				2.00
3.00	Total (sum of line 1 and line 2)		64,814,753		0		3.00
4.00	CHANGE IN RESTRICTED NET ASSETS	1,246		0		0	4.00
5.00	AUXILIARY NET INCOME	7,230		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)		8,476		0		10.00
11.00	Subtotal (line 3 plus line 10)		64,823,229		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)		64,823,229		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	CHANGE IN RESTRICTED NET ASSETS		0				4.00
5.00	AUXILIARY NET INCOME		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: 14-1301

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/14/2019 8:03 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,709,093		1,709,093	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	3,964,331		3,964,331	5.00
6.00	Swing bed - NF	1,119,019		1,119,019	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)	6,792,443		6,792,443	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)	6,792,443		6,792,443	17.00
18.00	Ancillary services	4,107,002	53,926,928	58,033,930	18.00
19.00	Outpatient services	23,774	11,464,647	11,488,421	19.00
20.00	RURAL HEALTH CLINIC	0	621,806	621,806	20.00
20.01	RURAL HEALTH CLINIC II	0	4,215,155	4,215,155	20.01
20.02	RURAL HEALTH CLINIC III	0	615,887	615,887	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,424,789	2,424,789	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	455,116	6,273,669	6,728,785	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,378,335	79,542,881	90,921,216	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,700,264		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	TIF EXPENSES	91,819			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)		91,819		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		37,608,445		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1301

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

Worksheet G-3

Date/Time Prepared:
11/14/2019 8:03 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	90,921,216	1.00
2.00	Less contractual allowances and discounts on patients' accounts	52,409,337	2.00
3.00	Net patient revenues (line 1 minus line 2)	38,511,879	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,608,445	4.00
5.00	Net income from service to patients (line 3 minus line 4)	903,434	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	306,169	6.00
7.00	Income from investments	517,124	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	210,243	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	50,074	23.00
24.00	TRUST HOSPITAL INCOME	1,178,952	24.00
24.01	EHR INCENTIVE REIMBURSEMENT	0	24.01
24.02	OTHER DOCTOR BUILDING INCOME	25,603	24.02
24.03	340B NET REVENUES	548,760	24.03
24.04	PHYSICAL THERAPY	37,331	24.04
24.05	AMBULANCE	58,032	24.05
24.06	CROSSFIT INCOME	153,591	24.06
24.07	TIF INCOME	37,569	24.07
24.08	MISCELLANEOUS INCOME	87,634	24.08
25.00	Total other income (sum of lines 6-24)	3,211,082	25.00
26.00	Total (line 5 plus line 25)	4,114,516	26.00
27.00	TIF EXPENSES	91,819	27.00
27.01	LOSS ON SALE OF ASSETS	47,229	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	139,048	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,975,468	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3438

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	72,016	0	72,016	0	72,016
2.00	Physician Assistant	99,009	0	99,009	0	99,009
3.00	Nurse Practitioner	11,329	0	11,329	0	11,329
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	102,247	0	102,247	0	102,247
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	7,836	1,425	9,261	0	9,261
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	292,437	1,425	293,862	0	293,862
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	40,706	40,706	0	40,706
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	40,706	40,706	0	40,706
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	292,437	42,131	334,568	0	334,568
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	11,414	11,414	-3,164	8,250
30.00	Administrative Costs	55,394	142,067	197,461	-72,044	125,417
31.00	Total Facility Overhead (sum of lines 29 and 30)	55,394	153,481	208,875	-75,208	133,667
32.00	Total facility costs (sum of lines 22, 28 and 31)	347,831	195,612	543,443	-75,208	468,235

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3438

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 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	72,016	1.00	
2.00	Physician Assistant	0	99,009	2.00	
3.00	Nurse Practitioner	0	11,329	3.00	
4.00	Visiting Nurse	0	0	4.00	
5.00	Other Nurse	0	102,247	5.00	
6.00	Clinical Psychologist	0	0	6.00	
7.00	Clinical Social Worker	0	9,261	7.00	
8.00	Laboratory Technician	0	0	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	0	293,862	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	40,706	15.00	
16.00	Transportation (Health Care Staff)	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	17.00	
18.00	Professional Liability Insurance	0	0	18.00	
19.00	Other Health Care Costs	0	0	19.00	
20.00	Allowable GME Costs			20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	40,706	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	334,568	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0	23.00	
24.00	Dental	0	0	24.00	
25.00	Optometry	0	0	25.00	
25.01	Telehealth	0	0	25.01	
25.02	Chronic Care Management	0	0	25.02	
26.00	All other nonreimbursable costs	0	0	26.00	
27.00	Nonallowable GME costs			27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00	
FACILITY OVERHEAD					
29.00	Facility Costs	0	8,250	29.00	
30.00	Administrative Costs	0	125,417	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	133,667	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	468,235	32.00	

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3495

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 am

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,058,890	0	1,058,890	0	1,058,890
2.00	Physician Assistant	339,364	0	339,364	0	339,364
3.00	Nurse Practitioner	145,436	0	145,436	0	145,436
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	650,757	0	650,757	0	650,757
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	51,941	34,492	86,433	0	86,433
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	2,246,388	34,492	2,280,880	0	2,280,880
11.00	Physician Services Under Agreement	0	49,332	49,332	0	49,332
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	49,332	49,332	0	49,332
15.00	Medical Supplies	0	206,809	206,809	0	206,809
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	206,809	206,809	0	206,809
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,246,388	290,633	2,537,021	0	2,537,021
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	2,010	0	2,010	0	2,010
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	2,010	0	2,010	0	2,010
FACILITY OVERHEAD						
29.00	Facility Costs	0	7,535	7,535	0	7,535
30.00	Administrative Costs	406,340	878,464	1,284,804	-309,569	975,235
31.00	Total Facility Overhead (sum of lines 29 and 30)	406,340	885,999	1,292,339	-309,569	982,770
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,654,738	1,176,632	3,831,370	-309,569	3,521,801

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-3495

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	1,058,890		1.00
2.00	Physician Assistant	0	339,364		2.00
3.00	Nurse Practitioner	0	145,436		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	650,757		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	86,433		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,280,880		10.00
11.00	Physician Services Under Agreement	0	49,332		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	49,332		14.00
15.00	Medical Supplies	0	206,809		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	206,809		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,537,021		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	2,010		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	2,010		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	-247	7,288		29.00
30.00	Administrative Costs	-600	974,635		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-847	981,923		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-847	3,520,954		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-8566

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 am

		RHC III		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificati ons	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	50,935	0	50,935	0	50,935
2.00	Physician Assistant	469	0	469	0	469
3.00	Nurse Practitioner	135,733	0	135,733	0	135,733
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	105,033	0	105,033	0	105,033
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	10,180	0	10,180	0	10,180
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	302,350	0	302,350	0	302,350
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	38,541	38,541	0	38,541
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	38,541	38,541	0	38,541
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	302,350	38,541	340,891	0	340,891
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	22,865	22,865	0	22,865
30.00	Administrative Costs	59,036	108,533	167,569	-72,634	94,935
31.00	Total Facility Overhead (sum of lines 29 and 30)	59,036	131,398	190,434	-72,634	117,800
32.00	Total facility costs (sum of lines 22, 28 and 31)	361,386	169,939	531,325	-72,634	458,691

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1301

Period:

Worksheet M-1

Component CCN: 14-8566

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC III	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	50,935		1.00
2.00	Physician Assistant	0	469		2.00
3.00	Nurse Practitioner	0	135,733		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	105,033		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	10,180		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	302,350		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	38,541		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	38,541		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	340,891		22.00
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	22,865		29.00
30.00	Administrative Costs	0	94,935		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	117,800		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	458,691		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES			Provider CCN: 14-1301 Component CCN: 14-3438		Period: From 07/01/2018 To 06/30/2019		Worksheet M-2 Date/Time Prepared: 11/14/2019 8:03 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	0.26	500	4,200	1,092			1.00
2.00	Physician Assistant	0.76	1,530	2,100	1,596			2.00
3.00	Nurse Practitioner	0.12	313	2,100	252			3.00
4.00	Subtotal (sum of lines 1 through 3)	1.14	2,343		2,940		2,940	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	0.11	186				186	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)	1.25	2,529				3,126	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)						334,568	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)						334,568	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)						133,667	14.00
15.00	Parent provider overhead allocated to facility (see instructions)						176,848	15.00
16.00	Total overhead (sum of lines 14 and 15)						310,515	16.00
17.00	Allowable GME overhead (see instructions)						0	17.00
18.00	Enter the amount from line 16						310,515	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						310,515	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						645,083	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301

Period:

Worksheet M-2

Component CCN: 14-3495

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 am

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	2.77	9,404	4,200	11,634		1.00
2.00	Physician Assistant	2.21	4,858	2,100	4,641		2.00
3.00	Nurse Practitioner	1.22	2,730	2,100	2,562		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.20	16,992		18,837	18,837	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	0.65	745			745	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)	6.85	17,737			19,582	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)					2,537,021	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					2,010	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					2,539,031	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999208	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					981,923	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,422,897	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,404,820	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,404,820	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,402,123	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					5,939,144	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1301

Period:

Worksheet M-2

Component CCN: 14-8566

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/14/2019 8:03 am

				RHC III		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.25	582	4,200	1,050		1.00
2.00	Physician Assistant	0.00	21	2,100	0		2.00
3.00	Nurse Practitioner	1.21	1,932	2,100	2,541		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.46	2,535		3,591	3,591	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	0.13	244			244	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)	1.59	2,779			3,835	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)					340,891	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)					340,891	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)					117,800	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					300,186	15.00
16.00	Total overhead (sum of lines 14 and 15)					417,986	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					417,986	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					417,986	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					758,877	20.00

Health Financial Systems		KIRBY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1301	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3	
		Component CCN: 14-3438		Date/Time Prepared: 11/14/2019 8:03 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)			645,083	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			14,864	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			630,219	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,126	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,126	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			201.61	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		201.61	201.61	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	399	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	80,442	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	80,442	16.00
16.01	Total program charges (see instructions)(from contractor's records)			85,904	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			4,508	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			4,221	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.)			55,138	16.04
16.05	Total program cost (see instructions)		0	59,359	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			7,299	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			14,819	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			59,359	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			4,051	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			63,410	22.00
23.00	Allowable bad debts (see instructions)			6,948	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			4,516	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,809	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)			67,926	26.00
26.01	Sequestration adjustment (see instructions)			1,359	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			55,245	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)			11,322	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/14/2019 8:03 am		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			5,939,144	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			70,616	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			5,868,528	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			19,582	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)			19,582	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			299.69	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)			0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)			299.69	299.69	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	3,333	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	998,867	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	998,867	16.00
16.01	Total program charges (see instructions)(from contractor's records)				742,002	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				37,128	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				49,981	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.)				712,436	16.04
16.05	Total program cost (see instructions)			0	762,417	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				58,341	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				129,306	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				762,417	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				22,704	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				785,121	22.00
23.00	Allowable bad debts (see instructions)				37,070	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				24,096	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				29,795	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)				809,217	26.00
26.01	Sequestration adjustment (see instructions)				16,184	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				692,414	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)				100,619	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/14/2019 8:03 am	
		Title XVIII	RHC III	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			758,877	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			11,865	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			747,012	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3,835	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3,835	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			194.79	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, \$20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		194.79	194.79	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	466	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	90,772	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	90,772	16.00
16.01	Total program charges (see instructions)(from contractor's records)			99,875	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			2,330	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			2,118	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			63,455	16.04
16.05	Total program cost (see instructions)		0	65,573	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			9,335	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			17,642	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			65,573	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			4,889	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			70,462	22.00
23.00	Allowable bad debts (see instructions)			1,309	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			851	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			706	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)			71,313	26.00
26.01	Sequestration adjustment (see instructions)			1,426	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			121,723	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)			-51,836	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: 14-1301 Component CCN: 14-3438	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/14/2019 8:03 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)		293,862	293,862	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000170	0.004816	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		50	1,415	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		1,162	5,082	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		1,212	6,497	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		334,568	334,568	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		310,515	310,515	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003623	0.019419	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,125	6,030	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		2,337	12,527	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		8	226	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		292.13	55.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		4	52	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		1,169	2,882	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)			14,864	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)			4,051	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/14/2019 8:03 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		2,280,880	2,280,880	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000253	0.003018	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		577	6,884	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		8,135	14,569	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		8,712	21,453	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		2,537,021	2,537,021	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		3,402,123	3,402,123	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.003434	0.008456	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		11,683	28,768	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		20,395	50,221	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		56	669	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		364.20	75.07	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		24	186	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		8,741	13,963	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)			70,616	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)			22,704	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/14/2019 8:03 am	
		Title XVIII	RHC III	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		302,350	302,350	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000268	0.002189	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		81	662	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		2,078	2,509	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		2,159	3,171	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		340,891	340,891	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		417,986	417,986	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.006333	0.009302	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		2,647	3,888	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		4,806	7,059	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		13	106	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		369.69	66.59	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		8	29	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		2,958	1,931	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)			11,865	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)			4,889	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1301 Component CCN: 14-3438	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/14/2019 8:03 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		55,245	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		55,245	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		11,322	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		66,567	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00 2.00		
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1301 Component CCN: 14-3495	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/14/2019 8:03 am
		RHC II	Cost	
		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		692,414	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		692,414	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		100,619	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		793,033	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1301 Component CCN: 14-8566	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/14/2019 8:03 am	
			RHC III	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC			121,723	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
Provider to Program					
3.50				0	3.50
3.51				0	3.51
3.52				0	3.52
3.53				0	3.53
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			121,723	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			51,836	6.02
7.00	Total Medicare program liability (see instructions)			69,887	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00