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Health Financial Systems WARNER HOSPITAL AND HEALTH SERVICES In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY Provider CCN: 14-1303 Period: From 05/01/2018 To 04/30/2019 Worksheet S Parts I-III Date/Time Prepared: 9/20/2019 10:35 am

PART I - COST REPORT STATUS

Provider use only 1. ☒ Electronically filed cost report Date: 9/20/2019 Time: 10:35 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 6. Date Received: 10. NPR Date:
(1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. ☐ Initial Report for this Provider CCN 12. ☐ If line 5, column 1 is 4: Enter
(3) Settled with Audit 9. ☐ Final Report for this Provider CCN number of times reopened = 0-9.
(4) Reopened
(5) Amended

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 WARNER HOSPITAL AND HEALTH SERVICES (14-1303) for the cost reporting period beginning 05/01/2018 and ending 04/30/2019 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.

Encryption Information

ECR: Date: 9/20/2019 Time: 10:35 am
c08Yf9.UgeEs8.hqfFQ12BUPbI2an0
vL2B60Fzvx0qfDUCRLITWMC0C:X3qY
kPQT0BLHC50.Ykfy

PI: Date: 9/20/2019 Time: 10:35 am
bFncby19CBE5NiATUJyI8c:1gaDVo0
v74240qN.08AbqSEwGEuqgT:rX2Bfx
BKEe0H:Jko0JYlq7

(Signed)

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Date

	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	43,019	101,182	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	12,718	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
10.00	RURAL HEALTH CLINIC I	0	0	86,750	0	10.00
200.00	Total	0	55,737	187,932	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: 14-1303		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/20/2019 10:35 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 422 WEST WHITE STREET			PO Box:				1.00	
2.00	City: CLINTON			State: IL		Zip Code: 61727		County: DEWITT 2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			WARNER HOSPITAL AND HEALTH SERVICES	141303	99914	1	03/01/2000	N
4.00	Subprovider - IPF							0	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			SWING BED	14Z303	99914		03/01/2000	N
8.00	Swing Beds - NF							0	N
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			RURAL HEALTH CENTER	143404	99914		07/03/1995	N
16.00	Hospital-Based Health Clinic - FQHC							0	N
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
17.20	Hospital-Based (OPT) I								
17.30	Hospital-Based (OOT) I								
17.40	Hospital-Based (OSP) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						05/01/2018	04/30/2019	20.00
21.00	Type of Control (see instructions)						12		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part I
Date/Time Prepared:
9/20/2019 10:35 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.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 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.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1303		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/20/2019 10:35 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
			1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).							61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06
			Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.					0.00	0.00	61.20
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						N	63.00
			Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00		2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part I
Date/Time Prepared:
9/20/2019 10:35 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
			1.00	2.00	3.00		
70.00	Inpatient Psychiatric Facility PPS						
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet S-2 Part I Date/Time Prepared: 9/20/2019 10:35 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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	78,392	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)	Y			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet S-2 Part I Date/Time Prepared: 9/20/2019 10:35 am
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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
						1.00	
						2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y	Y	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40	
						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)			05/01/2018	04/30/2019	170.00	
				1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N		0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1303		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part II Date/Time Prepared: 9/20/2019 10:35 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	08/12/2019	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	08/21/2019	Y	08/21/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
Date/Time Prepared:
9/20/2019 10:35 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		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.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANDREW	MCCABE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6660	AMCCABE@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
Date/Time Prepared:
9/20/2019 10:35 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/20/2019 10:35 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	15	5,475	11,108.28	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)		15	5,475	11,108.28	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)		15	5,475	11,108.28	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
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		15				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: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/20/2019 10:35 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)	262	0	346			1.00
2.00	HMO and other (see instructions)	31	17				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	48	0	79			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	20			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	310	0	445			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)	310	0	445	0.00	107.38	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC	6,797	0	16,777	0.00	23.85	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	131.23	27.00
28.00	Observation Bed Days		0	324			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/20/2019 10:35 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	91	0	145	1.00
2.00 HMO and other (see instructions)			12	9		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	91	0	145	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
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		WARNER HOSPITAL AND HEALTH SERVICES		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1303 Component CCN: 14-3404		Period: From 05/01/2018 To 04/30/2019 Worksheet S-8 Date/Time Prepared: 9/20/2019 10:35 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	422 W WHITE STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CLINTON IL		61727	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			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:30		19:00	07:30
				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			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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	DEWITT		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	19:00	07:30	19:00	07:30
				16:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1303 Component CCN: 14-3404		Period: From 05/01/2018 To 04/30/2019		Worksheet S-8 Date/Time Prepared: 9/20/2019 10:35 am	
						RHC I		Cost	
				Friday		Saturday			
				from	to	from	to		
				11.00	12.00	13.00	14.00		
Facility hours of operations (1)									
11.00	CLINIC			07:30	16:30	09:00	13:00	11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet S-10 Date/Time Prepared: 9/20/2019 10:35 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)			0.545474 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	2,199,198		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	6,539,869		6.00
7.00	Medicaid cost (line 1 times line 6)	3,567,329		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,368,131		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,368,131		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)	190,155	193,466	383,621 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	103,725	193,466	297,191 21.00
22.00	Payments received from patients for amounts previously written off as charity care	5,361	29,396	34,757 22.00
23.00	Cost of charity care (line 21 minus line 22)	98,364	164,070	262,434 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)	862,855		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	254,656		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	391,779		27.01
28.00	Non-Medicare bad debt expense (see instructions)	471,076		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	394,083		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	656,517		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,024,648		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		331,138	331,138	43,523	374,661	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		612,447	612,447	14,417	626,864	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,219,884	2,219,884	-187,481	2,032,403	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,077,625	1,384,252	2,461,877	-1,988	2,459,889	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	212,532	615,807	828,339	0	828,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,737	33,737	0	33,737	8.00
9.00	00900	HOUSEKEEPING	111,457	29,813	141,270	0	141,270	9.00
10.00	01000	DIETARY	131,544	102,215	233,759	-133,686	100,073	10.00
11.00	01100	CAFETERIA	0	0	0	130,063	130,063	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	126,984	9,557	136,541	0	136,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	62,511	286,064	348,575	-279,578	68,997	14.00
15.00	01500	PHARMACY	145,581	751,838	897,419	-253,908	643,511	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,830	75,592	271,422	0	271,422	16.00
17.00	01700	SOCIAL SERVICE	41,328	2,526	43,854	0	43,854	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	167,040	167,040	0	167,040	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	658,896	184,227	843,123	21,790	864,913	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	202,400	130,368	332,768	3,118	335,886	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	313,318	545,760	859,078	0	859,078	54.00
60.00	06000	LABORATORY	352,456	492,432	844,888	4,968	849,856	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	3,968	3,968	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	97,957	97,957	64.00
65.00	06500	RESPIRATORY THERAPY	184,804	46,879	231,683	-26,245	205,438	65.00
66.00	06600	PHYSICAL THERAPY	0	458,008	458,008	180	458,188	66.00
69.00	06900	ELECTROCARDIOLOGY	77,277	1,249	78,526	0	78,526	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	299,954	299,954	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,295	90,295	0	90,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	253,908	253,908	73.00
76.00	03950	CARDIAC REHAB	69,526	12,288	81,814	0	81,814	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,809,779	301,827	2,111,606	42,019	2,153,625	88.00
90.00	09000	CLINIC	0	0	0	3,505	3,505	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	914,890	1,259,814	2,174,704	-30,464	2,144,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		23,430	23,430	-23,430	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,688,738	10,168,487	16,857,225	-17,410	16,839,815	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	64,139	2,400	66,539	103	66,642	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	1,253	213	1,466	17,307	18,773	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	6,754,130	10,171,100	16,925,230	0	16,925,230	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A

Date/Time Prepared:
9/20/2019 10:35 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	-22,050	352,611	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-15,441	611,423	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	510,767	2,543,170	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-70,019	2,389,870	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	828,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	33,737	8.00
9.00	00900	HOUSEKEEPING	0	141,270	9.00
10.00	01000	DIETARY	-16,613	83,460	10.00
11.00	01100	CAFETERIA	-32,191	97,872	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	136,541	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	68,997	14.00
15.00	01500	PHARMACY	-185,286	458,225	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,334	264,088	16.00
17.00	01700	SOCIAL SERVICE	0	43,854	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	167,040	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-225,494	639,419	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-85,983	249,903	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	859,078	54.00
60.00	06000	LABORATORY	0	849,856	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,968	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	97,957	64.00
65.00	06500	RESPIRATORY THERAPY	-640	204,798	65.00
66.00	06600	PHYSICAL THERAPY	-10,361	447,827	66.00
69.00	06900	ELECTROCARDIOLOGY	-23,410	55,116	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-93	299,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,045	249,863	73.00
76.00	03950	CARDIAC REHAB	-450	81,364	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-20,833	2,132,792	88.00
90.00	09000	CLINIC	0	3,505	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	2,144,240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-209,476	16,630,339	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	66,642	192.00
192.01	19201	LIFELINE	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	18,773	192.03
192.04	19204	RENTAL PROPERTIES	0	0	192.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-209,476	16,715,754	200.00

RECLASSIFICATIONS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-6

Date/Time Prepared:
9/20/2019 10:35 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS CAFETERIA COSTS FROM DIET				
1.00	CAFETERIA	11.00	73,191	56,872	1.00
2.00	EMERGENCY	91.00	487	378	2.00
3.00	OPERATING ROOM	50.00	1,552	1,206	3.00
	TOTALS		75,230	58,456	
	B - TO RECLASS DRUGS SOLD TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	253,908	1.00
	TOTALS		0	253,908	
	C - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22,050	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,380	2.00
	TOTALS		0	23,430	
	D - TO RECLASS SUPPLIES CHARGED TO PTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	273,709	1.00
	TOTALS		0	273,709	
	F - TO RECLSS PROPERTY INS EXP				
1.00	OTHER CAP REL COSTS	3.00	0	34,613	1.00
	TOTALS		0	34,613	
	G - TO RECLASS RHC ADMIN EXPENSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	48,317	1.00
	TOTALS		0	48,317	
	H - TO RECLASS OXYGEN SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	26,245	1.00
	TOTALS		0	26,245	
	I - TO RECLASS NURSING COST				
1.00	INTRAVENOUS THERAPY	64.00	97,957	0	1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	3,968	0	2.00
3.00	CLINIC	90.00	3,505	0	3.00
	TOTALS		105,430	0	
	J - TO RECLASS GRANT EXPENSES				
1.00	RURAL HEALTH CLINIC	88.00	0	9,959	1.00
2.00	EMERGENCY	91.00	0	3,658	2.00
3.00	OPERATING ROOM	50.00	0	360	3.00
	TOTALS		0	13,977	
	K - TO RECLASS RHC PHYSICIAN TIME				
1.00	ADULTS & PEDIATRICS	30.00	77,736	14,497	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	9,024	1,821	2.00
	TOTALS		86,760	16,318	
	L - TO RECLASS ATHLETIC TRAINER COM BEN				
1.00	COMMUNITY BENEFIT	192.03	0	16,785	1.00
	TOTALS		0	16,785	
	N - TO RECLASS RHC LAB TESTS				
1.00	LABORATORY	60.00	4,968	0	1.00
	TOTALS		4,968	0	
	O - TO RECLASS RESTRICTED DONATIONS				
1.00	COMMUNITY BENEFIT	192.03	0	522	1.00
2.00	PHYSICAL THERAPY	66.00	0	16,965	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	942	3.00
	TOTALS		0	18,429	
	P - OP CLINIC MME DEPRECIATION				
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	103	1.00
	TOTALS		0	103	
	Q - DIRECT ASSIGN RHC PHYSICIAN BENEFITS				
1.00	RURAL HEALTH CLINIC	88.00	0	187,481	1.00
	TOTALS		0	187,481	
	R - CELLPHONE EXPENSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,869	1.00
	TOTALS		0	5,869	
500.00	Grand Total: Increases		272,388	977,640	500.00

RECLASSIFICATIONS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-6

Date/Time Prepared:
9/20/2019 10:35 am

	Decreases							9/26/2019 10:35 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - TO RECLASS CAFETERIA COSTS FROM DIET							
1.00	DIETARY	10.00	75,230	58,456	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
	TOTALS		75,230	58,456				
	B - TO RECLASS DRUGS SOLD TO PATIENTS							
1.00	PHARMACY	15.00	0	253,908	0			1.00
	TOTALS		0	253,908				
	C - TO RECLASS INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	23,430	11			1.00
2.00		0.00	0	0	11			2.00
	TOTALS		0	23,430				
	D - TO RECLASS SUPPLIES CHARGED TO PTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	273,709	0			1.00
	TOTALS		0	273,709				
	F - TO RECLSS PROPERTY INS EXP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,613	12			1.00
	TOTALS		0	34,613				
	G - TO RECLASS RHC ADMIN EXPENSES							
1.00	RURAL HEALTH CLINIC	88.00	0	48,317	0			1.00
	TOTALS		0	48,317				
	H - TO RECLASS OXYGEN SUPPLIES							
1.00	RESPIRATORY THERAPY	65.00	0	26,245	0			1.00
	TOTALS		0	26,245				
	I - TO RECLASS NURSING COST							
1.00	ADULTS & PEDIATRICS	30.00	70,443	0	0			1.00
2.00	EMERGENCY	91.00	34,987	0	0			2.00
3.00		0.00	0	0	0			3.00
	TOTALS		105,430	0				
	J - TO RECLASS GRANT EXPENSES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	13,977	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
	TOTALS		0	13,977				
	K - TO RECLASS RHC PHYSICIAN TIME							
1.00	RURAL HEALTH CLINIC	88.00	86,760	16,318	0			1.00
2.00		0.00	0	0	0			2.00
	TOTALS		86,760	16,318				
	L - TO RECLASS ATHLETIC TRAINER COM BEN							
1.00	PHYSICAL THERAPY	66.00	0	16,785	0			1.00
	TOTALS		0	16,785				
	N - TO RECLASS RHC LAB TESTS							
1.00	RURAL HEALTH CLINIC	88.00	4,968	0	0			1.00
	TOTALS		4,968	0				
	O - TO RECLASS RESTRICTED DONATIONS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	18,429	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
	TOTALS		0	18,429				
	P - OP CLINIC MME DEPRECIATION							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	103	9			1.00
	TOTALS		0	103				
	Q - DIRECT ASSIGN RHC PHYSICIAN BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	187,481	0			1.00
	TOTALS		0	187,481				
	R - CELLPHONE EXPENSES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,869	0			1.00
	TOTALS		0	5,869				
500.00	Grand Total: Decreases		272,388	977,640				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part I
Date/Time Prepared:
9/20/2019 10:35 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	422,168	39,331	0	39,331	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	11,044,104	755,925	0	755,925	150,464	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	128,511	75,372	0	75,372	0	5.00	
6.00	Movable Equipment	5,460,191	552,489	0	552,489	590,471	6.00	
7.00	HIT designated Assets	1,041,254	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	18,096,228	1,423,117	0	1,423,117	740,935	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	18,096,228	1,423,117	0	1,423,117	740,935	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	461,499	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	11,649,565	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	203,883	0				5.00	
6.00	Movable Equipment	5,422,209	0				6.00	
7.00	HIT designated Assets	1,041,254	0				7.00	
8.00	Subtotal (sum of lines 1-7)	18,778,410	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	18,778,410	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	331,138	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	612,447	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	943,585	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	331,138				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	612,447				2.00
3.00	Total (sum of lines 1-2)	0	943,585				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part III
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	11,649,565	0	11,649,565	0.620370	21,473	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,128,845	0	7,128,845	0.379630	13,140	2.00
3.00	Total (sum of lines 1-2)	18,778,410	0	18,778,410	1.000000	34,613	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	21,473	331,138	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,140	598,283	0	2.00
3.00	Total (sum of lines 1-2)	0	0	34,613	929,421	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	0	21,473	0	0	352,611	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,140	0	0	611,423	2.00
3.00	Total (sum of lines 1-2)	0	34,613	0	0	964,034	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-22,050	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,380	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	-1,369	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-334,887			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	64,780			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-32,191	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	B	-93	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-4,045	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,334	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,155	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN 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	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-6,794	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER INCOME	B	-11,218	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8

Date/Time Prepared:
9/20/2019 10:35 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	
34.00	OUTSIDE DIETARY SERVICES	B	-15,458	DIETARY	10.00	0	34.00
35.00	RESTING METABOLIC INCOME	B	-640	RESPIRATORY THERAPY	65.00	0	35.00
36.00	FITNESS MGMT	B	-6,070	PHYSICAL THERAPY	66.00	0	36.00
37.00	NON-ALLOW AMORTIZATION	A	-20,833	RURAL HEALTH CLINIC	88.00	0	37.00
38.00	EHR DEPRECIATION - CAPITAL LEAS	A	-7,267	CAP REL COSTS-MVBLE EQUIP	2.00	9	38.00
39.00	OTHER REVENUE - RHC	B	0	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	PEACE MEAL STAFF TIME	A	-1,326	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	LOBBYING EXPENSE	A	-6,981	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	ADVERTISING AND MARKETING	A	-92,908	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	NON-ALLOWABLE PT PURCHASED SERVICE	A	-4,291	PHYSICAL THERAPY	66.00	0	43.00
44.00	CLINICAL TRAINING CLASSES	B	0	NURSING ADMINISTRATION	13.00	0	44.00
45.00	PENSION DIFFERENTIAL	A	510,767	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.00
46.00	340B PROGRAM EXPENSES	A	-185,286	PHARMACY	15.00	0	46.00
47.00	OTHER REVENUE - CARDIAC REHAB	B	-450	CARDIAC REHAB	76.00	0	47.00
48.00	NON-ALLOWABLE CONTRIBUTIONS	A	-14,262	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	INTEREST FROM INSURANCE COMPANIES	B	-6,735	ADMINISTRATIVE & GENERAL	5.00	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-209,476				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-1

Date/Time Prepared:
9/20/2019 10:35 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION & GENERAL	64,780	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			64,780	0	5.00

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

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

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

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

6.00	B		0.00	CITY OF CLINTON	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-1

Date/Time Prepared:
9/20/2019 10:35 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	64,780	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	64,780			5.00

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

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

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

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

6.00	CITY GOVERNMENT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet A-8-2

Date/Time Prepared:
9/20/2019 10:35 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	60.00	LABORATORY	3,067	0	3,067	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	23,410	23,410	0	0	0	2.00
3.00	50.00	OPERATING ROOM	85,983	85,983	0	0	0	3.00
4.00	91.00	EMERGENCY	1,189,398	0	1,189,398	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	225,494	225,494	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,527,352	334,887	1,192,465		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	23,410		2.00
3.00	50.00	OPERATING ROOM	0	0	0	85,983		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	225,494		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	334,887		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1303		Period: From 05/01/2018 To 04/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/20/2019 10:35 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					254	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					5.55	7.00
8.00	Optional travel expense rate per mile					0.54	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,056.25	3,059.25	1,199.25	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.14	60.89	13.78	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)	41.57	41.57	30.45			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)					254,097	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					186,278	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					440,375	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					16,526	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)					456,901	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)					456,901	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)					10,559	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					10,559	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,410	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,969	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)					11,969	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: 14-1303		Period: From 05/01/2018 To 04/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 9/20/2019 10:35 am		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.14	60.89	13.78	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)						456,901	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						11,969	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)						468,870	63.00
64.00	Total cost of outside supplier services (from your records)						276,147	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						10,559	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,410	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						11,969	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						1,410	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						1,410	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: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	352,611	352,611			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	611,423		611,423		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,543,170	0	0	2,543,170	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,389,870	52,394	94,879	486,223	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	828,339	49,489	89,617	95,894	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,737	5,298	9,595	0	8.00
9.00	00900	HOUSEKEEPING	141,270	1,880	3,405	50,289	9.00
10.00	01000	DIETARY	83,460	13,084	23,694	25,409	10.00
11.00	01100	CAFETERIA	97,872	0	0	33,024	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	136,541	3,463	6,270	57,295	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,997	7,602	13,767	28,205	14.00
15.00	01500	PHARMACY	458,225	4,684	8,483	65,686	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	264,088	12,255	22,192	88,358	16.00
17.00	01700	SOCIAL SERVICE	43,854	0	0	18,647	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	167,040	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	639,419	30,043	54,403	265,508	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	249,903	33,961	61,499	92,023	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	859,078	13,648	24,714	141,368	54.00
60.00	06000	LABORATORY	849,856	7,090	12,839	161,269	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,968	0	0	1,790	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	97,957	1,975	3,576	44,198	64.00
65.00	06500	RESPIRATORY THERAPY	204,798	3,444	6,236	83,383	65.00
66.00	06600	PHYSICAL THERAPY	447,827	15,078	27,305	0	66.00
69.00	06900	ELECTROCARDIOLOGY	55,116	1,621	2,935	34,867	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	299,861	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	90,295	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	249,863	0	0	0	73.00
76.00	03950	CARDIAC REHAB	81,364	3,412	6,179	31,370	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,132,792	61,122	110,685	310,050	88.00
90.00	09000	CLINIC	3,505	0	0	1,581	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,144,240	16,097	29,150	397,229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,630,339	337,640	611,423	2,513,666	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	66,642	14,971	0	28,939	192.00
192.01	19201	LIFELINE	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	18,773	0	0	565	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	192.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	16,715,754	352,611	611,423	2,543,170	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,023,366					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	234,792	0	1,298,131			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,738	0	27,432	86,800		8.00
9.00	00900	HOUSEKEEPING	43,464	0	9,734	0	250,042	9.00
10.00	01000	DIETARY	32,160	0	67,743	0	13,433	10.00
11.00	01100	CAFETERIA	28,903	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	44,949	0	17,927	0	3,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,181	0	39,361	0	7,805	14.00
15.00	01500	PHARMACY	118,590	0	24,252	0	4,809	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	85,428	0	63,450	0	12,582	16.00
17.00	01700	SOCIAL SERVICE	13,801	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	36,883	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	218,459	0	155,544	86,800	30,843	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	96,577	0	175,831	0	34,866	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	229,375	0	70,660	0	14,011	54.00
60.00	06000	LABORATORY	227,663	0	36,706	0	7,279	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,271	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	32,614	0	10,225	0	2,028	64.00
65.00	06500	RESPIRATORY THERAPY	65,769	0	17,829	0	3,535	65.00
66.00	06600	PHYSICAL THERAPY	108,241	0	78,067	0	15,480	66.00
69.00	06900	ELECTROCARDIOLOGY	20,875	0	8,390	0	1,664	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	66,211	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,938	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,171	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	27,010	0	17,665	0	3,503	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	577,337	0	316,462	0	62,753	88.00
90.00	09000	CLINIC	1,123	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	571,162	0	83,343	0	16,526	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,994,685	0	1,220,621	86,800	234,672	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	24,411	0	77,510	0	15,370	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	4,270	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,023,366	0	1,298,131	86,800	250,042	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	258,983					10.00
11.00	01100	CAFETERIA	0	159,799				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,892	0	273,892		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,916	0	0	193,834	14.00
15.00	01500	PHARMACY	0	4,462	0	0	3,497	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,002	0	0	17	16.00
17.00	01700	SOCIAL SERVICE	0	1,267	0	5,168	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	154	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	258,983	20,417	0	73,591	5,755	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,251	0	25,154	8,743	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,603	0	0	10,756	54.00
60.00	06000	LABORATORY	0	10,954	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	122	0	495	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	3,002	0	12,212	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,664	0	0	1,012	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	956	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,368	0	0	365	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	106,729	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	35,209	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	2,131	0	8,647	776	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	52,655	0	31,347	5,120	88.00
90.00	09000	CLINIC	0	107	0	437	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	26,982	0	108,865	14,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	258,983	157,795	0	265,916	193,639	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,966	0	7,976	195	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	38	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	258,983	159,799	0	273,892	193,834	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	692,688					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	554,372				16.00
17.00	01700	SOCIAL SERVICE	0	0	82,737			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	204,077		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	16,285	82,737	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	21,511	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	11,522	0	204,077	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	142,650	0	0	0	54.00
60.00	06000	LABORATORY	0	101,858	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	953	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	30,326	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,273	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	43,230	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,306	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,538	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,503	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	614,390	25,861	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	2,933	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	78,298	58,678	0	0	0	88.00
90.00	09000	CLINIC	0	513	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	63,432	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	692,688	554,372	82,737	204,077	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	692,688	554,372	82,737	204,077	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	1,938,787	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	806,319	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	215,599	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,515,863	0	54.00
60.00	06000	LABORATORY	0	0	0	1,415,514	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	8,599	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	0	238,113	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	398,943	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	736,184	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	138,507	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	487,339	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	147,945	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	945,285	0	73.00
76.00	03950	CARDIAC REHAB	0	0	0	184,990	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,797,299	0	88.00
90.00	09000	CLINIC	0	0	0	7,266	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	3,471,576	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	16,454,128	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	237,980	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	23,646	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	16,715,754	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		1,938,787	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	CARDIAC REHAB	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
90.01	09001	PROVIDER BASED CLINIC	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		16,454,128	
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.01	19201	LIFELINE	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	192.02
192.03	19203	COMMUNITY BENEFIT	192.03
192.04	19204	RENTAL PROPERTIES	192.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		237,980	
		0	
		0	
		23,646	
		0	
		0	
		0	
		16,715,754	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	52,394	94,879	147,273	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	49,489	89,617	139,106	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,298	9,595	14,893	0	8.00
9.00	00900	HOUSEKEEPING	0	1,880	3,405	5,285	0	9.00
10.00	01000	DIETARY	0	13,084	23,694	36,778	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	3,463	6,270	9,733	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,602	13,767	21,369	0	14.00
15.00	01500	PHARMACY	0	4,684	8,483	13,167	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,255	22,192	34,447	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	30,043	54,403	84,446	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33,961	61,499	95,460	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,648	24,714	38,362	0	54.00
60.00	06000	LABORATORY	0	7,090	12,839	19,929	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	1,975	3,576	5,551	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,444	6,236	9,680	0	65.00
66.00	06600	PHYSICAL THERAPY	0	15,078	27,305	42,383	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,621	2,935	4,556	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	3,412	6,179	9,591	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	61,122	110,685	171,807	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	16,097	29,150	45,247	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	337,640	611,423	949,063	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	14,971	0	14,971	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	352,611	611,423	964,034	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	147,273					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	11,437	0	150,543			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	523	0	3,181	18,597		8.00
9.00	00900	HOUSEKEEPING	2,117	0	1,129	0	8,531	9.00
10.00	01000	DIETARY	1,567	0	7,856	0	458	10.00
11.00	01100	CAFETERIA	1,408	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,190	0	2,079	0	121	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,275	0	4,565	0	266	14.00
15.00	01500	PHARMACY	5,777	0	2,813	0	164	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,161	0	7,358	0	429	16.00
17.00	01700	SOCIAL SERVICE	672	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,797	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,642	0	18,038	18,597	1,052	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,705	0	20,391	0	1,190	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,173	0	8,194	0	478	54.00
60.00	06000	LABORATORY	11,090	0	4,257	0	248	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,589	0	1,186	0	69	64.00
65.00	06500	RESPIRATORY THERAPY	3,204	0	2,068	0	121	65.00
66.00	06600	PHYSICAL THERAPY	5,273	0	9,053	0	528	66.00
69.00	06900	ELECTROCARDIOLOGY	1,017	0	973	0	57	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,225	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	971	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,688	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	1,316	0	2,049	0	120	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	28,119	0	36,699	0	2,142	88.00
90.00	09000	CLINIC	55	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	27,823	0	9,665	0	564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145,876	0	141,554	18,597	8,007	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,189	0	8,989	0	524	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	208	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	147,273	0	150,543	18,597	8,531	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	46,659					10.00
11.00	01100	CAFETERIA	0	1,408				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	34	0	14,157		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17	0	0	27,492	14.00
15.00	01500	PHARMACY	0	39	0	0	496	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53	0	0	2	16.00
17.00	01700	SOCIAL SERVICE	0	11	0	267	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	22	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,659	180	0	3,804	816	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	55	0	1,300	1,240	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85	0	0	1,525	54.00
60.00	06000	LABORATORY	0	97	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1	0	26	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	26	0	631	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	50	0	0	144	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	136	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21	0	0	52	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	15,137	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0	19	0	447	110	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	464	0	1,620	726	88.00
90.00	09000	CLINIC	0	1	0	23	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	238	0	5,627	2,064	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,659	1,391	0	13,745	27,464	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	17	0	412	28	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,659	1,408	0	14,157	27,492	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	22,456					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,450				16.00
17.00	01700	SOCIAL SERVICE	0	0	950			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,819		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,365	950			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,803	0			50.00
53.00	05300	ANESTHESIOLOGY	0	965	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,949	0			54.00
60.00	06000	LABORATORY	0	8,535	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	80	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
64.00	06400	INTRAVENOUS THERAPY	0	2,541	0			64.00
65.00	06500	RESPIRATORY THERAPY	0	609	0			65.00
66.00	06600	PHYSICAL THERAPY	0	3,623	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	864	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,218	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	210	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,918	2,167	0			73.00
76.00	03950	CARDIAC REHAB	0	246	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,538	4,917	0			88.00
90.00	09000	CLINIC	0	43	0			90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0			90.01
91.00	09100	EMERGENCY	0	5,315	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,456	46,450	950	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
192.01	19201	LIFELINE	0	0	0			192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0			192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0			192.03
192.04	19204	RENTAL PROPERTIES	0	0	0			192.04
200.00		Cross Foot Adjustments				1,819		0 200.00
201.00		Negative Cost Centers	0	0	0	0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	22,456	46,450	950	1,819		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				186,549	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				126,144	0	50.00
53.00	05300	ANESTHESIOLOGY				965	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				71,766	0	54.00
60.00	06000	LABORATORY				44,156	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				169	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
64.00	06400	INTRAVENOUS THERAPY				11,593	0	64.00
65.00	06500	RESPIRATORY THERAPY				15,876	0	65.00
66.00	06600	PHYSICAL THERAPY				60,996	0	66.00
69.00	06900	ELECTROCARDIOLOGY				7,540	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				19,580	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				6,175	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				24,773	0	73.00
76.00	03950	CARDIAC REHAB				13,898	0	76.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPS				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC				249,032	0	88.00
90.00	09000	CLINIC				122	0	90.00
90.01	09001	PROVIDER BASED CLINIC				0	0	90.01
91.00	09100	EMERGENCY				96,543	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	935,877	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES				26,130	0	192.00
192.01	19201	LIFELINE				0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT				0	0	192.02
192.03	19203	COMMUNITY BENEFIT				208	0	192.03
192.04	19204	RENTAL PROPERTIES				0	0	192.04
200.00		Cross Foot Adjustments	0	0	0	1,819	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	964,034	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	186,549
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	126,144
53.00	05300	ANESTHESIOLOGY	965
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,766
60.00	06000	LABORATORY	44,156
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	169
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0
64.00	06400	INTRAVENOUS THERAPY	11,593
65.00	06500	RESPIRATORY THERAPY	15,876
66.00	06600	PHYSICAL THERAPY	60,996
69.00	06900	ELECTROCARDIOLOGY	7,540
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,580
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,175
73.00	07300	DRUGS CHARGED TO PATIENTS	24,773
76.00	03950	CARDIAC REHAB	13,898
76.97	07697	CARDIAC REHABILITATION	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0
76.99	07699	LITHOTRIPSY	0
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	249,032
90.00	09000	CLINIC	122
90.01	09001	PROVIDER BASED CLINIC	0
91.00	09100	EMERGENCY	96,543
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	935,877
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS PRIVATE OFFICES	26,130
192.01	19201	LIFELINE	0
192.02	19202	HOME MEDICAL EQUIPMENT	0
192.03	19203	COMMUNITY BENEFIT	208
192.04	19204	RENTAL PROPERTIES	0
200.00		Cross Foot Adjustments	1,819
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	964,034

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,704					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		53,339				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,636,492			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,277	8,277	1,077,625	-3,023,366	13,692,388	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,818	7,818	212,532	0	1,063,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	837	837	0	0	48,630	8.00
9.00	00900	HOUSEKEEPING	297	297	111,457	0	196,844	9.00
10.00	01000	DIETARY	2,067	2,067	56,314	0	145,647	10.00
11.00	01100	CAFETERIA	0	0	73,191	0	130,896	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	547	547	126,984	0	203,569	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,201	1,201	62,511	0	118,571	14.00
15.00	01500	PHARMACY	740	740	145,581	0	537,078	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,936	1,936	195,830	0	386,893	16.00
17.00	01700	SOCIAL SERVICE	0	0	41,328	0	62,501	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	167,040	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,746	4,746	588,453	0	989,373	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,365	5,365	203,952	0	437,386	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,156	2,156	313,318	0	1,038,808	54.00
60.00	06000	LABORATORY	1,120	1,120	357,424	0	1,031,054	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	3,968	0	5,758	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	312	312	97,957	0	147,706	64.00
65.00	06500	RESPIRATORY THERAPY	544	544	184,804	0	297,861	65.00
66.00	06600	PHYSICAL THERAPY	2,382	2,382	0	0	490,210	66.00
69.00	06900	ELECTROCARDIOLOGY	256	256	77,277	0	94,539	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	299,861	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	90,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	249,863	73.00
76.00	03950	CARDIAC REHAB	539	539	69,526	0	122,325	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	9,656	9,656	687,173	0	2,614,649	88.00
90.00	09000	CLINIC	0	0	3,505	0	5,086	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,543	2,543	880,390	0	2,586,716	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,339	53,339	5,571,100	-3,023,366	13,562,498	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	2,365	0	64,139	0	110,552	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	1,253	0	19,338	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	352,611	611,423	2,543,170		3,023,366	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.330084	11.462963	0.451197		0.220806	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		147,273	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.010756	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: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	39,609			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	837	769		8.00
9.00	00900	HOUSEKEEPING	0	297	0	38,475	9.00
10.00	01000	DIETARY	0	2,067	0	2,067	769 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	547	0	547	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,201	0	1,201	0 14.00
15.00	01500	PHARMACY	0	740	0	740	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,936	0	1,936	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	4,746	769	4,746	769 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,365	0	5,365	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,156	0	2,156	0 54.00
60.00	06000	LABORATORY	0	1,120	0	1,120	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
64.00	06400	INTRAVENOUS THERAPY	0	312	0	312	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	544	0	544	0 65.00
66.00	06600	PHYSICAL THERAPY	0	2,382	0	2,382	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	256	0	256	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03950	CARDIAC REHAB	0	539	0	539	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	9,656	0	9,656	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0 90.01
91.00	09100	EMERGENCY	0	2,543	0	2,543	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	37,244	769	36,110	769 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,365	0	2,365	0 192.00
192.01	19201	LIFELINE	0	0	0	0	0 192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0 192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0 192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0 192.04
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)	0	1,298,131	86,800	250,042	258,983 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	32.773637	112.873862	6.498817	336.778934 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	150,543	18,597	8,531	46,659 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.800727	24.183355	0.221728	60.674902 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DA YS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	
			6.00	7.00	8.00	9.00	10.00	
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: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:

9/20/2019 10:35 am

Cost Center Description			CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSG SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	5,213,987					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	126,984	0	2,196,938			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	62,511	0	0	497,094		14.00
15.00	01500	PHARMACY	145,581	0	0	8,967	495,165	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,830	0	0	44	0	16.00
17.00	01700	SOCIAL SERVICE	41,328	0	41,451	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	396	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	666,189	0	590,283	14,758	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	203,952	0	201,768	22,423	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	313,318	0	0	27,583	0	54.00
60.00	06000	LABORATORY	357,424	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,968	0	3,968	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	97,957	0	97,957	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	184,804	0	0	2,595	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,451	0	66.00
69.00	06900	ELECTROCARDIOLOGY	77,277	0	0	936	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	273,709	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	90,295	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	439,194	73.00
76.00	03950	CARDIAC REHAB	69,526	0	69,359	1,991	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,718,051	0	251,439	13,130	55,971	88.00
90.00	09000	CLINIC	3,505	0	3,505	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	880,390	0	873,229	37,315	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,148,595	0	2,132,959	496,593	495,165	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	64,139	0	63,979	501	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	1,253	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	159,799	0	273,892	193,834	692,688	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.030648	0.000000	0.124670	0.389934	1.398903	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,408	0	14,157	27,492	22,456	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000270	0.000000	0.006444	0.055305	0.045351	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSG SALARY)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
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: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,164,853					16.00
17.00	01700	SOCIAL SERVICE	0	769				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	886,119	769	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,170,471	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	626,933	0	100	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,761,953	0	0	0	0	54.00
60.00	06000	LABORATORY	5,542,366	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	51,855	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	1,650,105	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	395,763	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,352,283	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	560,769	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	791,038	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	136,183	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,407,174	0	0	0	0	73.00
76.00	03950	CARDIAC REHAB	159,593	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,192,815	0	0	0	0	88.00
90.00	09000	CLINIC	27,905	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,451,528	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,164,853	769	100	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	LIFELINE	0	0	0	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	0	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	0	0	0	192.04
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)	554,372	82,737	204,077	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.018378	107.590377	2,040.770000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,450	950	1,819	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DA YS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001540	1.235371	18.190000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet B-1
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
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
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	CARDIAC REHAB	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0	0	90.01
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
192.01	19201	LIFELINE	0	0	192.01
192.02	19202	HOME MEDICAL EQUIPMENT	0	0	192.02
192.03	19203	COMMUNITY BENEFIT	0	0	192.03
192.04	19204	RENTAL PROPERTIES	0	0	192.04
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)	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet B-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00		
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/20/2019 10:35 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,938,787		1,938,787	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	806,319		806,319	0	0	50.00
53.00	05300	ANESTHESIOLOGY	215,599		215,599	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,515,863		1,515,863	0	0	54.00
60.00	06000	LABORATORY	1,415,514		1,415,514	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,599		8,599	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	238,113		238,113	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	398,943	0	398,943	0	0	65.00
66.00	06600	PHYSICAL THERAPY	736,184	0	736,184	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	138,507		138,507	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	487,339		487,339	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	147,945		147,945	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	945,285		945,285	0	0	73.00
76.00	03950	CARDIAC REHAB	184,990		184,990	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,797,299		3,797,299	0	0	88.00
90.00	09000	CLINIC	7,266		7,266	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	3,471,576		3,471,576	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	837,582		837,582	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,291,710	0	17,291,710	0	0	200.00
201.00		Less Observation Beds	837,582		837,582			201.00
202.00		Total (see instructions)	16,454,128	0	16,454,128	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/20/2019 10:35 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	470,700		470,700		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	247,496	922,975	1,170,471	0.688884	0.000000
53.00	05300	ANESTHESIOLOGY	153,263	473,670	626,933	0.343895	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,209	7,397,744	7,761,953	0.195294	0.000000
60.00	06000	LABORATORY	337,740	5,204,626	5,542,366	0.255399	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	51,855	51,855	0.165828	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	111,784	1,538,321	1,650,105	0.144302	0.000000
65.00	06500	RESPIRATORY THERAPY	110,736	285,027	395,763	1.008035	0.000000
66.00	06600	PHYSICAL THERAPY	21,750	2,330,533	2,352,283	0.312966	0.000000
69.00	06900	ELECTROCARDIOLOGY	23,498	537,271	560,769	0.246995	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	441,430	349,608	791,038	0.616075	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	136,183	136,183	1.086369	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	293,141	1,114,033	1,407,174	0.671761	0.000000
76.00	03950	CARDIAC REHAB	0	159,593	159,593	1.159136	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,192,815	3,192,815		88.00
90.00	09000	CLINIC	0	27,905	27,905	0.260383	0.000000
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	113,415	3,338,113	3,451,528	1.005808	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	40,718	374,701	415,419	2.016234	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,729,880	27,434,973	30,164,853		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,729,880	27,434,973	30,164,853		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/20/2019 10:35 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
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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 CARDIAC REHAB	0.000000			76.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 PROVIDER BASED CLINIC	0.000000			90.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/20/2019 10:35 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,938,787		1,938,787	0	1,938,787	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	806,319		806,319	0	806,319	50.00
53.00	05300	ANESTHESIOLOGY	215,599		215,599	0	215,599	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,515,863		1,515,863	0	1,515,863	54.00
60.00	06000	LABORATORY	1,415,514		1,415,514	0	1,415,514	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,599		8,599	0	8,599	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	238,113		238,113	0	238,113	64.00
65.00	06500	RESPIRATORY THERAPY	398,943	0	398,943	0	398,943	65.00
66.00	06600	PHYSICAL THERAPY	736,184	0	736,184	0	736,184	66.00
69.00	06900	ELECTROCARDIOLOGY	138,507		138,507	0	138,507	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	487,339		487,339	0	487,339	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	147,945		147,945	0	147,945	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	945,285		945,285	0	945,285	73.00
76.00	03950	CARDIAC REHAB	184,990		184,990	0	184,990	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,797,299		3,797,299	0	3,797,299	88.00
90.00	09000	CLINIC	7,266		7,266	0	7,266	90.00
90.01	09001	PROVIDER BASED CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	3,471,576		3,471,576	0	3,471,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	837,582		837,582	0	837,582	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,291,710	0	17,291,710	0	17,291,710	200.00
201.00		Less Observation Beds	837,582		837,582		837,582	201.00
202.00		Total (see instructions)	16,454,128	0	16,454,128	0	16,454,128	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/20/2019 10:35 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	470,700		470,700		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	247,496	922,975	1,170,471	0.688884	0.000000
53.00	05300	ANESTHESIOLOGY	153,263	473,670	626,933	0.343895	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	364,209	7,397,744	7,761,953	0.195294	0.000000
60.00	06000	LABORATORY	337,740	5,204,626	5,542,366	0.255399	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	51,855	51,855	0.165828	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	111,784	1,538,321	1,650,105	0.144302	0.000000
65.00	06500	RESPIRATORY THERAPY	110,736	285,027	395,763	1.008035	0.000000
66.00	06600	PHYSICAL THERAPY	21,750	2,330,533	2,352,283	0.312966	0.000000
69.00	06900	ELECTROCARDIOLOGY	23,498	537,271	560,769	0.246995	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	441,430	349,608	791,038	0.616075	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	136,183	136,183	1.086369	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	293,141	1,114,033	1,407,174	0.671761	0.000000
76.00	03950	CARDIAC REHAB	0	159,593	159,593	1.159136	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,192,815	3,192,815	1.189326	0.000000
90.00	09000	CLINIC	0	27,905	27,905	0.260383	0.000000
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	113,415	3,338,113	3,451,528	1.005808	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	40,718	374,701	415,419	2.016234	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,729,880	27,434,973	30,164,853		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,729,880	27,434,973	30,164,853		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	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
60.00	06000 LABORATORY	0.000000			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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 CARDIAC REHAB	0.000000			76.00
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699 LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 PROVIDER BASED CLINIC	0.000000			90.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description			Title XVIII		Hospital	Cost	
			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	126,144	1,170,471	0.107772	33,403	3,600
53.00	05300	ANESTHESIOLOGY	965	626,933	0.001539	18,827	29
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,766	7,761,953	0.009246	169,564	1,568
60.00	06000	LABORATORY	44,156	5,542,366	0.007967	134,742	1,073
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	169	51,855	0.003259	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
64.00	06400	INTRAVENOUS THERAPY	11,593	1,650,105	0.007026	0	0
65.00	06500	RESPIRATORY THERAPY	15,876	395,763	0.040115	75,425	3,026
66.00	06600	PHYSICAL THERAPY	60,996	2,352,283	0.025931	9,793	254
69.00	06900	ELECTROCARDIOLOGY	7,540	560,769	0.013446	7,347	99
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,580	791,038	0.024752	80,251	1,986
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,175	136,183	0.045343	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	24,773	1,407,174	0.017605	112,743	1,985
76.00	03950	CARDIAC REHAB	13,898	159,593	0.087084	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	249,032	3,192,815	0.077998	0	0
90.00	09000	CLINIC	122	27,905	0.004372	0	0
90.01	09001	PROVIDER BASED CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	96,543	3,451,528	0.027971	9,517	266
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	80,591	415,419	0.193999	1,479	287
200.00		Total (lines 50 through 199)	829,919	29,694,153		653,091	14,173

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet D
Part IV
Date/Time Prepared:
9/20/2019 10:35 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	23,680	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 CARDIAC REHAB	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 PROVIDER BASED CLINIC	0	0	0	0	0	90.01
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
200.00	Total (lines 50 through 199)	23,680	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet D
Part IV
Date/Time Prepared:
9/20/2019 10:35 am

				Title XVIII		Hospital	Cost		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
			4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	1,170,471	0.000000	50.00	
53.00	05300	ANESTHESIOLOGY	0	23,680	0	626,933	0.037771	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,761,953	0.000000	54.00	
60.00	06000	LABORATORY	0	0	0	5,542,366	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	51,855	0.000000	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,650,105	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	395,763	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	2,352,283	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	560,769	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	791,038	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	136,183	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,407,174	0.000000	73.00	
76.00	03950	CARDIAC REHAB	0	0	0	159,593	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,192,815	0.000000	88.00	
90.00	09000	CLINIC	0	0	0	27,905	0.000000	90.00	
90.01	09001	PROVIDER BASED CLINIC	0	0	0	0	0.000000	90.01	
91.00	09100	EMERGENCY	0	0	0	3,451,528	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	415,419	0.000000	92.00	
200.00	Total (lines 50 through 199)		0	23,680	0	29,694,153		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet D
Part IV
Date/Time Prepared:
9/20/2019 10:35 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	33,403	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	18,827	711	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	169,564	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	134,742	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	75,425	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	9,793	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,347	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	80,251	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	112,743	0	0	0	73.00
76.00	03950	CARDIAC REHAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	9,517	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,479	0	0	0	92.00
200.00		Total (lines 50 through 199)		653,091	711	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
9/20/2019 10:35 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	0.688884	0	318,562	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.343895	0	167,905	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195294	0	2,909,569	0	0	54.00
60.00	06000	LABORATORY	0.255399	0	2,165,678	857	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.165828	0	36,611	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
64.00	06400	INTRAVENOUS THERAPY	0.144302	0	765,564	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1.008035	0	113,178	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.312966	0	676,262	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.246995	0	230,833	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.616075	0	138,616	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.086369	0	47,268	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.671761	0	473,503	0	0	73.00
76.00	03950	CARDIAC REHAB	1.159136	0	78,054	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.260383	0	14,862	0	0	90.00
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	1.005808	0	916,912	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.016234	0	225,538	0	0	92.00
200.00		Subtotal (see instructions)		0	9,278,915	857	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	9,278,915	857	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
9/20/2019 10:35 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	219,452	0		50.00
53.00	05300	ANESTHESIOLOGY	57,742	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	568,221	0		54.00
60.00	06000	LABORATORY	553,112	219		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,071	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
64.00	06400	INTRAVENOUS THERAPY	110,472	0		64.00
65.00	06500	RESPIRATORY THERAPY	114,087	0		65.00
66.00	06600	PHYSICAL THERAPY	211,647	0		66.00
69.00	06900	ELECTROCARDIOLOGY	57,015	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	85,398	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,350	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	318,081	0		73.00
76.00	03950	CARDIAC REHAB	90,475	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	3,870	0		90.00
90.01	09001	PROVIDER BASED CLINIC	0	0		90.01
91.00	09100	EMERGENCY	922,237	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	454,737	0		92.00
200.00		Subtotal (see instructions)	3,823,967	219		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,823,967	219		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1303

Period:

Worksheet D

Component CCN: 14-Z303

From 05/01/2018
To 04/30/2019Part V
Date/Time Prepared:
9/20/2019 10:35 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	0.688884	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.343895	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195294	0	0	0	0	54.00	
60.00	06000	LABORATORY	0.255399	0	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.165828	0	0	0	0	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
64.00	06400	INTRAVENOUS THERAPY	0.144302	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	1.008035	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.312966	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.246995	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.616075	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.086369	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.671761	0	0	0	0	73.00	
76.00	03950	CARDIAC REHAB	1.159136	0	0	0	0	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00	
90.00	09000	CLINIC	0.260383	0	0	0	0	90.00	
90.01	09001	PROVIDER BASED CLINIC	0.000000	0	0	0	0	90.01	
91.00	09100	EMERGENCY	1.005808	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.016234	0	0	0	0	92.00	
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: 14-1303

Period:

Worksheet D

Component CCN: 14-Z303

From 05/01/2018
To 04/30/2019Part V
Date/Time Prepared:
9/20/2019 10:35 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
60.00	06000	LABORATORY	0	0				60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
64.00	06400	INTRAVENOUS THERAPY	0	0				64.00
65.00	06500	RESPIRATORY THERAPY	0	0				65.00
66.00	06600	PHYSICAL THERAPY	0	0				66.00
69.00	06900	ELECTROCARDIOLOGY	0	0				69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
76.00	03950	CARDIAC REHAB	0	0				76.00
76.97	07697	CARDIAC REHABILITATION	0	0				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0				76.98
76.99	07699	LITHOTRIPSY	0	0				76.99
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0				88.00
90.00	09000	CLINIC	0	0				90.00
90.01	09001	PROVIDER BASED CLINIC	0	0				90.01
91.00	09100	EMERGENCY	0	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
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: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1 Date/Time Prepared: 9/20/2019 10:35 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)		769	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		670	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)		346	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		75	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)		4	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		9	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)		11	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		262	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)		33	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)		15	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		120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,938,787	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)		1,086	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)		1,442	25.00
26.00	Total swing-bed cost (see instructions)		206,753	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,732,034	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)		1,732,034	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)		2,585.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		677,304	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)		677,304	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/20/2019 10:35 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)					315,656		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					992,960		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)					85,309		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					38,777		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					124,086		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)					324		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,585.13		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					837,582		89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/20/2019 10:35 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	186,549	1,938,787	0.096219	837,582	80,591
91.00	Nursing School cost	0	1,938,787	0.000000	837,582	0
92.00	Allied health cost	0	1,938,787	0.000000	837,582	0
93.00	All other Medical Education	0	1,938,787	0.000000	837,582	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet D-1 Date/Time Prepared: 9/20/2019 10:35 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			769 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			670 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)			346 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			45 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)			34 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			9 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)			11 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			0 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		131.13	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,938,787	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)		1,086	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)		1,442	25.00
26.00	Total swing-bed cost (see instructions)		206,753	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,732,034	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)		1,732,034	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)		2,585.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					324	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,585.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					837,582	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet D-1

Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		Title XIX		Hospital		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	186,549	1,938,787	0.096219	837,582	80,591	90.00
91.00	Nursing School cost	0	1,938,787	0.000000	837,582	0	91.00
92.00	Allied health cost	0	1,938,787	0.000000	837,582	0	92.00
93.00	All other Medical Education	0	1,938,787	0.000000	837,582	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 9/20/2019 10:35 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		307,988		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.688884	33,403	23,011	50.00
53.00	05300 ANESTHESIOLOGY	0.343895	18,827	6,475	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195294	169,564	33,115	54.00
60.00	06000 LABORATORY	0.255399	134,742	34,413	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.165828	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.144302	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	1.008035	75,425	76,031	65.00
66.00	06600 PHYSICAL THERAPY	0.312966	9,793	3,065	66.00
69.00	06900 ELECTROCARDIOLOGY	0.246995	7,347	1,815	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.616075	80,251	49,441	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.086369	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.671761	112,743	75,736	73.00
76.00	03950 CARDIAC REHAB	1.159136	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.260383	0	0	90.00
90.01	09001 PROVIDER BASED CLINIC	0.000000	0	0	90.01
91.00	09100 EMERGENCY	1.005808	9,517	9,572	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.016234	1,479	2,982	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		653,091	315,656	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)		653,091		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1303 Component CCN: 14-Z303	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 9/20/2019 10:35 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	0.688884	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.343895	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195294	1,187	232	54.00
60.00	06000 LABORATORY	0.255399	11,030	2,817	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.165828	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
64.00	06400 INTRAVENOUS THERAPY	0.144302	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	1.008035	12,251	12,349	65.00
66.00	06600 PHYSICAL THERAPY	0.312966	5,837	1,827	66.00
69.00	06900 ELECTROCARDIOLOGY	0.246995	237	59	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.616075	14,214	8,757	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.086369	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.671761	18,643	12,524	73.00
76.00	03950 CARDIAC REHAB	1.159136	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.260383	0	0	90.00
90.01	09001 PROVIDER BASED CLINIC	0.000000	0	0	90.01
91.00	09100 EMERGENCY	1.005808	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.016234	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		63,399	38,565	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)		63,399		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part B Date/Time Prepared: 9/20/2019 10:35 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,824,186	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)		3,824,186	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)		3,862,428	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)		13,060	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,432,442	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)		2,416,926	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)		2,416,926	30.00
31.00	Primary payer payments		19	31.00
32.00	Subtotal (line 30 minus line 31)		2,416,907	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)		239,189	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		155,473	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		183,556	36.00
37.00	Subtotal (see instructions)		2,572,380	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)		2,572,380	40.00
40.01	Sequestration adjustment (see instructions)		51,448	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,419,750	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		101,182	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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet E-1
Part I
Date/Time Prepared:
9/20/2019 10:35 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		951,123		2,557,740	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	04/17/2019	90,541	04/17/2019	137,990	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)		-90,541		-137,990	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)		860,582		2,419,750	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		43,019		101,182	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		903,601		2,520,932	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1303

Period:

Worksheet E-1

Component CCN: 14-Z303

From 05/01/2018
To 04/30/2019Part I
Date/Time Prepared:
9/20/2019 10:35 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		177,156		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	04/17/2019	29,718		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)		-29,718		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)		147,438		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		12,718		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		160,156		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet E-1
Part II
Date/Time Prepared:
9/20/2019 10:35 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: 14-1303 Component CCN: 14-Z303	Period: From 05/01/2018 To 04/30/2019	Worksheet E-2 Date/Time Prepared: 9/20/2019 10:35 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)	125,327	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)	38,951	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	48	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)	164,278	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	164,278	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)	164,278	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	853	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)	163,425	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)	163,425	0	19.00
19.01	Sequestration adjustment (see instructions)	3,269	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	147,438	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)	12,718	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
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet E-3 Part V Date/Time Prepared: 9/20/2019 10:35 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		992,960	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)		992,960	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		1,002,890	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)		1,002,890	19.00
20.00	Deductibles (exclude professional component)		95,836	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		907,054	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		907,054	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23,059	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		14,988	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,731	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		922,042	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)		922,042	30.00
30.01	Sequestration adjustment (see instructions)		18,441	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		860,582	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)		43,019	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet E-3 Part VII Date/Time Prepared: 9/20/2019 10:35 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinsurance		0		33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet G

Date/Time Prepared:
9/20/2019 10:35 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	2,623,913	0	0	0	1.00
2.00	Temporary investments	6,832,646	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,169,262	0	0	0	4.00
5.00	Other receivable	664,814	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,965,615	0	0	0	6.00
7.00	Inventory	315,306	0	0	0	7.00
8.00	Prepaid expenses	221,017	0	0	0	8.00
9.00	Other current assets	41,025	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)	12,902,368	0	0	0	11.00
FIXED ASSETS						
12.00	Land	461,498	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	11,649,566	0	0	0	15.00
16.00	Accumulated depreciation	-8,579,489	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	203,883	0	0	0	19.00
20.00	Accumulated depreciation	-91,786	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	5,422,209	0	0	0	23.00
24.00	Accumulated depreciation	-3,891,707	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	1,041,254	0	0	0	27.00
28.00	Accumulated depreciation	-1,041,254	0	0	0	28.00
29.00	Minor equipment-nondepreciable	530,929	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,705,103	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,138,038	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	1,678,928	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,816,966	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	22,424,437	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,047,584	0	0	0	37.00
38.00	Salaries, wages, and fees payable	843,313	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	30,000	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	221,575	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,142,472	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	600,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,623,059	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,223,059	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,365,531	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	17,058,906				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)	17,058,906	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	22,424,437	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet G-1

Date/Time Prepared:
9/20/2019 10:35 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		15,168,546		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,833,921				2.00
3.00	Total (sum of line 1 and line 2)		17,002,467		0		3.00
4.00	CAPITAL GRANTS AND GIFTS	54,763		0		0	4.00
5.00	UNREALIZED GAINS	1,676		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)		56,439		0		10.00
11.00	Subtotal (line 3 plus line 10)		17,058,906		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)		17,058,906		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	CAPITAL GRANTS AND GIFTS		0				4.00
5.00	UNREALIZED GAINS		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: 14-1303

Period:
From 05/01/2018
To 04/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
9/20/2019 10:35 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	396,780		396,780	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	73,920		73,920	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	470,700		470,700	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)	470,700		470,700	17.00
18.00	Ancillary services	2,259,180	24,242,158	26,501,338	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	3,192,815	3,192,815	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	56,858	188,433	245,291	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,786,738	27,623,406	30,410,144	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,925,230		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,925,230		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1303

Period:
From 05/01/2018
To 04/30/2019

Worksheet G-3

Date/Time Prepared:
9/20/2019 10:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	30,410,144	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,870,019	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,540,125	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,925,230	4.00
5.00	Net income from service to patients (line 3 minus line 4)	614,895	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	58,689	6.00
7.00	Income from investments	81,549	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	32,191	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	93	16.00
17.00	Revenue from sale of drugs to other than patients	4,045	17.00
18.00	Revenue from sale of medical records and abstracts	7,334	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,155	21.00
22.00	Rental of hospital space	34,100	22.00
23.00	Governmental appropriations	231,388	23.00
24.00	OTHER DIETARY REVENUE	15,458	24.00
24.01	SALE: MINOR EQUIPMENT/SUPPLIES	0	24.01
24.02	FITNESS CENTER	6,070	24.02
24.03	PHARM 340B RETAIL/CONTRACT REV	681,622	24.03
24.04	MISC OTHER	12,308	24.04
24.05	CRNA PASS THROUGH AND OTHER	0	24.05
24.06	MEDICAID EHR	51,000	24.06
24.07	MEDICARE EHR	0	24.07
25.00	Total other income (sum of lines 6-24)	1,217,002	25.00
26.00	Total (line 5 plus line 25)	1,831,897	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
27.01	LOSS ON DISPOSAL OF ASSET	-2,024	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	-2,024	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,833,921	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1303

Period:

Worksheet M-1

Component CCN: 14-3404

From 05/01/2018
To 04/30/2019Date/Time Prepared:
9/20/2019 10:35 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	743,959	0	743,959	23,216	767,175	1.00
2.00	Physician Assistant	0	0	0	61,187	61,187	2.00
3.00	Nurse Practitioner	360,434	0	360,434	0	360,434	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	251,797	0	251,797	-4,968	246,829	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	410,642	68,537	479,179	0	479,179	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,766,832	68,537	1,835,369	79,435	1,914,804	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	77,787	77,787	0	77,787	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	77,787	77,787	0	77,787	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,766,832	146,324	1,913,156	79,435	1,992,591	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	10,317	10,317	0	10,317	29.00
30.00	Administrative Costs	42,946	145,186	188,132	-37,415	150,717	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	42,946	155,503	198,449	-37,415	161,034	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,809,778	301,827	2,111,605	42,020	2,153,625	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1303

Period:

Worksheet M-1

Component CCN: 14-3404

From 05/01/2018
To 04/30/2019Date/Time Prepared:
9/20/2019 10:35 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	767,175	1.00
2.00	Physician Assistant	0	61,187	2.00
3.00	Nurse Practitioner	0	360,434	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	246,829	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	479,179	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,914,804	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	77,787	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	77,787	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,992,591	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	10,317	29.00
30.00	Administrative Costs	-20,833	129,884	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-20,833	140,201	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-20,833	2,132,792	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1303

Period:

Worksheet M-2

Component CCN: 14-3404

From 05/01/2018
To 04/30/2019Date/Time Prepared:
9/20/2019 10:35 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.58	10,654	4,200	6,636		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.03	5,670	2,100	4,263		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.61	16,324		10,899	16,324	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	0.21	453			453	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.82	16,777			16,777	8.00
9.00	Physician Services Under Agreements		0			0	9.00
							1.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES							
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,992,591	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,992,591	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)					140,201	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,664,507	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,804,708	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,804,708	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,804,708	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,797,299	20.00

Health Financial Systems		WARNER HOSPITAL AND HEALTH SERVICES		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1303	Period: From 05/01/2018 To 04/30/2019	Worksheet M-3	
		Component CCN: 14-3404		Date/Time Prepared: 9/20/2019 10:35 am	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,797,299	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			92,425	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,704,874	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			16,777	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)			16,777	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			220.83	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)		82.30	83.45	8.00
9.00	Rate for Program covered visits (see instructions)		220.83	220.83	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	6,683	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,475,807	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	114	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	25,175	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	25,175	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	1,500,982	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,140,142	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			3,727	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			4,907	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.)			1,109,534	16.04
16.05	Total program cost (see instructions)		0	1,114,441	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			109,157	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			205,427	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			1,114,441	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			51,198	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			1,165,639	22.00
23.00	Allowable bad debts (see instructions)			129,531	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			84,195	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			122,161	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)			1,249,834	26.00
26.01	Sequestration adjustment (see instructions)			24,997	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,138,087	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)			86,750	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: 14-1303 Component CCN: 14-3404	Period: From 05/01/2018 To 04/30/2019	Worksheet M-4 Date/Time Prepared: 9/20/2019 10:35 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,914,804	1,914,804	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001389	0.003033	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		2,660	5,808	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		27,814	12,217	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		30,474	18,025	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,992,591	1,992,591	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,804,708	1,804,708	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.015294	0.009046	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		27,601	16,325	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		58,075	34,350	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		175	382	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		331.86	89.92	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		99	204	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		32,854	18,344	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)			92,425	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)			51,198	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1303 Component CCN: 14-3404	Period: From 05/01/2018 To 04/30/2019	Worksheet M-5 Date/Time Prepared: 9/20/2019 10:35 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		1,138,087	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)		1,138,087	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		86,750	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,224,837	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	
		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101	8.00