

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1304	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/19/2019 8:31 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/19/2019	Time: 8:31 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GENESIS MEDICAL CENTER - ALEDO (14-1304) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MARK ROGERS
Officer or Administrator of Provider(s)

VICE PRESIDENT FINANCE / CFO
Title

11/19/2019 08:31:24 AM
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	59,507	245,139	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	35,138	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		1,179		0	10.00
200.00	Total	0	94,645	246,318	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1304		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 8:31 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 409 N.W. NINTH AVENUE			PO Box:		Date Certified		Payment System (P, T, O, or N)	
2.00	City: ALEDO			State: IL		Zip Code: 61231-		County: MERCER	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
				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		GENESIS MEDICAL CENTER - ALEDO	141304	19340	1	05/01/2000	N	O O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		GENESIS MEDICAL CENTER - ALEDO, SWB	14Z304	19340		05/01/2000	N	O N
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC		GENESIS MEDICAL CENTER - ALEDO, RHC	143453	19340		02/29/2000	N	O N
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019	
21.00	Type of Control (see instructions)						2		
							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		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/19/2019 8:31 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	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 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					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: 14-1304		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 8:31 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
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
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					70.00
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	
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
	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	
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

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Health Financial Systems		GENESIS MEDICAL CENTER - ALEDO		In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1304	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 8:31 am				
			1.00					
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.06		
Rural Providers								
105.00	Does this hospital qualify as a CAH?			Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			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.			N	Y	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: 14-1304	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 8:31 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:	14,489	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		H55790	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1304		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/19/2019 8:31 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: GENESIS HEALTH SYSTEM		Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH			Contractor's Number: 05001			141.00	
142.00	Street: 1227 E RUSHOLME STREET		PO Box:							142.00
143.00	City: DAVENPORT		State: IA		Zip Code:		52803			143.00
									1.00	
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
									1.00	
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.								N	146.00
									1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
									1.00	
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00	166.00
									1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								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)					10/01/2017	09/30/2019		170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N			0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1304		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part II Date/Time Prepared: 11/19/2019 8:31 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)			Y			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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	10/25/2019	Y	10/25/2019
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	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/19/2019 8:31 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.		Y		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.	MARTY	ORWITZ		41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(563) 421 - 4175	ORWITZM@GENESISHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1304	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/19/2019 8:31 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/19/2019 8:31 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	22	8,030	5,904.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		22	8,030	5,904.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		22	8,030	5,904.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		22				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: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/19/2019 8:31 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)	155	7	246			1.00
2.00	HMO and other (see instructions)	50	10				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	520	0	748			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	29			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	675	7	1,023			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)	675	7	1,023	0.00	76.60	14.00
15.00	CAH visits	5,175	378	17,019			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,041	8	21,827	0.00	22.02	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	98.62	27.00
28.00	Observation Bed Days		3	275			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: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/19/2019 8:31 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	49	4	146	1.00
2.00 HMO and other (see instructions)			30	6		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	49	4	146	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1304 Component CCN: 14-3453		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/19/2019 8:31 am	
		RHC I		Cost			
		1.00					
Clinic Address and Identification							
1.00	Street	1007 NW 3RD STREET				1.00	
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County	ALEDO		IL 61231		2.00	
				1.00			
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0		3.00	
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)					4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00	
7.00	Appalachian Regional Commission					7.00	
8.00	Look-Alikes					8.00	
9.00	OTHER (SPECIFY)					9.00	
		1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0		10.00	
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)							
11.00	CLINIC	07:00		18:00		08:00	
		1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?	N				12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0		13.00	
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number					14.00	
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
		County					
		4.00					
2.00	City, State, ZIP Code, County	MERCER				2.00	
		Tuesday	Wednesday	Thursday			
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)							
11.00	CLINIC	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2018 To 06/30/2019	Worksheet S-8 Date/Time Prepared: 11/19/2019 8:31 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		07:00	18:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1304

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

Worksheet S-10

Date/Time Prepared:
11/19/2019 8:31 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)		0.550271	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		391,089	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		3,222,570	6.00
7.00	Medicaid cost (line 1 times line 6)		1,773,287	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)		1,382,198	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		5,000	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)		1,382,198	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)	354,981	0	354,981
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	195,336	0	195,336
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	195,336	0	195,336
			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)		824,106	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		58,605	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		90,161	27.01
28.00	Non-Medicare bad debt expense (see instructions)		733,945	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		435,425	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		630,761	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,012,959	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1304

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

Worksheet A

Date/Time Prepared:
11/19/2019 8:31 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		765,100	765,100	16,349	781,449	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		452,067	452,067	17,838	469,905	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,036	739,233	747,269	0	747,269	4.00
5.01	00570	ADMITTING	116,544	14,219	130,763	0	130,763	5.01
5.02	00590	HOSPITAL ONLY A & G	0	181,630	181,630	0	181,630	5.02
5.03	00591	SHARED ADMN & GENERAL	307,039	2,740,436	3,047,475	206,652	3,254,127	5.03
6.00	00600	MAINTENANCE & REPAIRS	91	495,131	495,222	4,951	500,173	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,903	2,174	31,077	0	31,077	8.00
9.00	00900	HOUSEKEEPING	0	190,487	190,487	0	190,487	9.00
10.00	01000	DIETARY	0	64,337	64,337	0	64,337	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,671	10,204	26,875	0	26,875	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	54,066	5,193	59,259	0	59,259	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	214,113	214,113	-30,721	183,392	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	886,498	199,613	1,086,111	-11,460	1,074,651	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	152,042	130,043	282,085	-46,638	235,447	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	456,608	341,549	798,157	-4,442	793,715	54.00
60.00	06000	LABORATORY	447,265	549,361	996,626	-23,617	973,009	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	23,617	23,617	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	209,802	51,356	261,158	-575	260,583	65.00
66.00	06600	PHYSICAL THERAPY	287,324	106,435	393,759	-17,845	375,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	17,237	17,237	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	608	608	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	62,134	62,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,824	10,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	223,458	594,211	817,669	-342,651	475,018	73.00
76.00	03950	SLEEP LAB	19,217	7,646	26,863	-611	26,252	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,031,677	439,937	2,471,614	-246,686	2,224,928	88.00
91.00	09100	EMERGENCY	788,336	1,594,044	2,382,380	-7,581	2,374,799	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		306,294	306,294	0	306,294	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,033,577	10,194,813	16,228,390	-372,617	15,855,773	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	359,801	117,148	476,949	29,966	506,915	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	342,651	342,651	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	6,393,378	10,311,961	16,705,339	0	16,705,339	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1304

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

Worksheet A

Date/Time Prepared:
11/19/2019 8:31 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	0	781,449	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-24,499	445,406	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-174,230	573,039	4.00
5.01	00570	ADMITTING	0	130,763	5.01
5.02	00590	HOSPITAL ONLY A & G	-4,848	176,782	5.02
5.03	00591	SHARED ADMN & GENERAL	-764,573	2,489,554	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	500,173	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	31,077	8.00
9.00	00900	HOUSEKEEPING	0	190,487	9.00
10.00	01000	DIETARY	0	64,337	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,533	39,408	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	155,807	155,807	16.00
17.00	01700	SOCIAL SERVICE	0	59,259	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	183,392	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,074,651	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	235,447	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-254	793,461	54.00
60.00	06000	LABORATORY	0	973,009	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	23,617	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-16,429	244,154	65.00
66.00	06600	PHYSICAL THERAPY	-4,924	370,990	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,237	67.00
68.00	06800	SPEECH PATHOLOGY	0	608	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	62,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,267	472,751	73.00
76.00	03950	SLEEP LAB	0	26,252	76.00
76.01	03951	DIABETIC EDUCATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-81,093	2,143,835	88.00
91.00	09100	EMERGENCY	-179,041	2,195,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-306,294	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,390,112	14,465,661	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-145,265	361,650	192.00
194.00	07950	RETAIL PHARMACY	0	342,651	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,535,377	15,169,962	200.00

RECLASSIFICATIONS

Provider CCN: 14-1304

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

Worksheet A-6

Date/Time Prepared:
11/19/2019 8:31 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - RHC SALARY					
1.00	SHARED ADMN & GENERAL	5.03	225,610	15,229	1.00
	0		225,610	15,229	
B - BLOOD					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	5,291	18,326	1.00
	0		5,291	18,326	
C - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	72,958	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	72,958	
D - IMPLANTABLE DEVICES CHARGED TO PTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,824	1.00
	0		0	10,824	
E - RETAIL PHARMACY					
1.00	RETAIL PHARMACY	194.00	95,681	246,970	1.00
	0		95,681	246,970	
F - CRNA					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	30,721	1.00
	0		0	30,721	
G - THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	17,237	1.00
2.00	SPEECH PATHOLOGY	68.00	0	608	2.00
	TOTALS		0	17,845	
H - RHC UTILITIES					
1.00	MAINTENANCE & REPAIRS	6.00	0	4,951	1.00
	TOTALS		0	4,951	
I - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,349	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,838	2.00
	TOTALS		0	34,187	
500.00	Grand Total: Increases		326,582	452,011	500.00

RECLASSIFICATIONS

Provider CCN: 14-1304

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

Worksheet A-6

Date/Time Prepared:
11/19/2019 8:31 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	A - RHC SALARY						
	RURAL HEALTH CLINIC	88.00	225,610	15,229	0		1.00
			225,610	15,229			
1.00	B - BLOOD						
	LABORATORY	60.00	5,291	18,326	0		1.00
			5,291	18,326			
	C - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	11,460	0		1.00
2.00	OPERATING ROOM	50.00	0	46,638	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,442	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	575	0		4.00
5.00	SLEEP LAB	76.00	0	611	0		5.00
6.00	RURAL HEALTH CLINIC	88.00	0	896	0		6.00
7.00	EMERGENCY	91.00	0	7,581	0		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	755	0		8.00
			0	72,958			
	D - IMPLANTABLE DEVICES CHARGED TO PTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,824	0		1.00
			0	10,824			
	E - RETAIL PHARMACY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	95,681	246,970	0		1.00
			95,681	246,970			
1.00	F - CRNA						
	NONPHYSICIAN ANESTHETISTS	19.00	0	30,721	0		1.00
			0	30,721			
	G - THERAPY						
1.00	PHYSICAL THERAPY	66.00	0	17,845	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	17,845			
	H - RHC UTILITIES						
1.00	RURAL HEALTH CLINIC	88.00	0	4,951	0		1.00
	TOTALS		0	4,951			
	I - PROPERTY INSURANCE						
1.00	SHARED ADMN & GENERAL	5.03	0	34,187	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	34,187			
500.00	Grand Total: Decreases		326,582	452,011			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/19/2019 8:31 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,000	0	0	0	0	1.00
2.00	Land Improvements	326,868	0	0	0	0	2.00
3.00	Buildings and Fixtures	12,646,848	254,035	0	254,035	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,301,741	0	0	0	-866,027	5.00
6.00	Movable Equipment	109,793	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,450,250	254,035	0	254,035	-866,027	8.00
9.00	Reconciling Items	-1,085,719	0	0	0	-496,142	9.00
10.00	Total (line 8 minus line 9)	16,535,969	254,035	0	254,035	-369,885	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
		PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES					
1.00	Land	65,000	0				1.00
2.00	Land Improvements	326,868	0				2.00
3.00	Buildings and Fixtures	12,900,883	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	3,167,768	0				5.00
6.00	Movable Equipment	109,793	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	16,570,312	0				8.00
9.00	Reconciling Items	-589,577	0				9.00
10.00	Total (line 8 minus line 9)	17,159,889	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/19/2019 8:31 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	765,100	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	452,067	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,217,167	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	765,100				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	452,067				2.00
3.00	Total (sum of lines 1-2)	0	1,217,167				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/19/2019 8:31 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	16,460,520	0	16,460,520	0.993374	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	109,793	0	109,793	0.006626	0	2.00
3.00	Total (sum of lines 1-2)	16,570,313	0	16,570,313	1.000000	0	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	0	765,100	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	427,568	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,192,668	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	16,349	0	0	781,449	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,838	0	0	445,406	2.00
3.00	Total (sum of lines 1-2)	0	34,187	0	0	1,226,855	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1304

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

Worksheet A-8

Date/Time Prepared:
11/19/2019 8:31 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)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0	0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B		0SHARED ADMN & GENERAL	5.03	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0	0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-1,610	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-193,406			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	-415,570			0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests			0	0.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts			0	0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-22,852	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1304

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

Worksheet A-8

Date/Time Prepared:
11/19/2019 8:31 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	
33.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-8,493	SHARED ADMN & GENERAL	5.03	0	33.00
33.01	OTHER REVENUE - MISCELLANEOUS REVENU	B	-2,267	DRUGS CHARGED TO PATIENTS	73.00	0	33.01
33.02	OTHER REVENUE - MISCELLANEOUS REVENU	B	-79,217	RURAL HEALTH CLINIC	88.00	0	33.02
33.03	PATIENT PHONES DEPRECIATION	A	-37	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.03
33.04	PATIENT PHONES SALARY	A	-678	RURAL HEALTH CLINIC	88.00	0	33.04
33.05	PATIENT PHONES BENEFITS	A	-79	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	PATIENT PHONES COST	A	-33	SHARED ADMN & GENERAL	5.03	0	33.06
33.07	ADVERTISING	A	-13,753	SHARED ADMN & GENERAL	5.03	0	33.07
33.08	ADVERTISING	A	-254	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	ADVERTISING	A	-4,924	PHYSICAL THERAPY	66.00	0	33.09
33.10	ADVERTISING	A	-1,198	RURAL HEALTH CLINIC	88.00	0	33.10
33.11	ADVERTISING	A	-2,064	EMERGENCY	91.00	0	33.11
33.12	ADVERTISING	A	-268	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.12
33.13	PROVIDER TAX ASSESSMENT	A	-385,810	SHARED ADMN & GENERAL	5.03	0	33.13
33.14	IHA LOBBYING FEES	A	-6,190	SHARED ADMN & GENERAL	5.03	0	33.14
33.15	EMPLOYEE HEALTH INSURANCE	A	-174,151	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	DONATIONS	A	-500	SHARED ADMN & GENERAL	5.03	0	33.16
33.17	PHYSICIAN PRACTICE OVERHEAD	A	-77,026	SHARED ADMN & GENERAL	5.03	0	33.17
34.00	PROFESSIONAL FEES OFFSET 100% PART B	A	-144,997	PHYSICIANS' PRIVATE OFFICES	192.00	0	34.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,535,377				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: 14-1304

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

Worksheet A-8-1

Date/Time Prepared:
11/19/2019 8:31 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	5.03	SHARED ADMN & GENERAL	HOME OFFICE EQUIP CAPITAL	284,091	0	1.00
2.00	5.02	HOSPITAL ONLY A & G	SBS PATIENT ACCOUNTING	176,715	181,563	2.00
3.00	5.03	SHARED ADMN & GENERAL	INFORMATION TECHNOLOGY	161,837	778,917	3.00
4.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE POOLED	883,974	1,268,670	4.00
4.01	5.03	SHARED ADMN & GENERAL	HOME OFFICE ADMIN COSTS	10,166	0	4.01
4.02	5.03	SHARED ADMN & GENERAL	SBS PATIENT ACCESS	143,980	0	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	TRANSCRIPTION	155,807	0	4.03
4.04	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	12,533	0	4.04
4.05	5.03	SHARED ADMN & GENERAL	MEDICAL AFFAIRS	23,611	0	4.05
4.06	5.03	SHARED ADMN & GENERAL	PASTORAL CARE	11,606	0	4.06
4.07	5.03	SHARED ADMN & GENERAL	PAYOR CONTRACTING	8,520	0	4.07
4.10	5.03	SHARED ADMN & GENERAL	HOME OFFICE ADMIN COSTS	18,486	0	4.10
4.11	5.03	SHARED ADMN & GENERAL	LIBRARY	6,248	0	4.11
4.12	5.03	SHARED ADMN & GENERAL	AFFILIATE FACILITIES	222,300	0	4.12
4.13	5.01	ADMITTING	VARIOUS SERVICES - RELATED	406	406	4.13
4.14	6.00	MAINTENANCE & REPAIRS	VARIOUS SERVICES - RELATED	6,052	6,052	4.14
4.15	30.00	ADULTS & PEDIATRICS	VARIOUS SERVICES - RELATED	15,361	15,361	4.15
4.16	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	2,325	2,325	4.16
4.17	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS SERVICES - RELATED	2,636	2,636	4.17
4.18	60.00	LABORATORY	VARIOUS SERVICES - RELATED	72,529	72,529	4.18
4.19	65.00	RESPIRATORY THERAPY	VARIOUS SERVICES - RELATED	4,275	4,275	4.19
4.20	66.00	PHYSICAL THERAPY	VARIOUS SERVICES - RELATED	669	669	4.20
4.21	73.00	DRUGS CHARGED TO PATIENTS	VARIOUS SERVICES - RELATED	27,602	27,602	4.21
4.22	76.00	SLEEP LAB	VARIOUS SERVICES - RELATED	16	16	4.22
4.24	88.00	RURAL HEALTH CLINIC	VARIOUS SERVICES - RELATED	469	469	4.24
4.25	91.00	EMERGENCY	VARIOUS SERVICES - RELATED	10,925	10,925	4.25
4.26	192.00	PHYSICIANS' PRIVATE OFFICES	VARIOUS SERVICES - RELATED	964	964	4.26
4.27	194.00	RETAIL PHARMACY	VARIOUS SERVICES - RELATED	207,044	207,044	4.27
4.28	113.00	INTEREST EXPENSE	INTEREST EXPENSE RELATED	0	306,294	4.28
4.29	88.00	RURAL HEALTH CLINIC	GHG MGMT FEE - %	74,992	74,992	4.29
4.30	192.00	PHYSICIANS' PRIVATE OFFICES	GHG MGMT FEE - %	18,637	18,637	4.30
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,564,776	2,980,346	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	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00

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	B	GMC ALEDO	100.00	GENESIS HLTH SY	100.00	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

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

Provider CCN: 14-1304

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

Worksheet A-8-1

Date/Time Prepared:
11/19/2019 8:31 am

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
				Name	Percentage of Ownership
	1.00	2.00	3.00	4.00	5.00

(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: 14-1304

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

Worksheet A-8-1

Date/Time Prepared:
11/19/2019 8:31 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	284,091	9		1.00
2.00	-4,848	0		2.00
3.00	-617,080	0		3.00
4.00	-384,696	0		4.00
4.01	10,166	0		4.01
4.02	143,980	0		4.02
4.03	155,807	0		4.03
4.04	12,533	0		4.04
4.05	23,611	0		4.05
4.06	11,606	0		4.06
4.07	8,520	0		4.07
4.10	18,486	0		4.10
4.11	6,248	0		4.11
4.12	222,300	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	-306,294	0		4.28
4.29	0	0		4.29
4.30	0	0		4.30
5.00	-415,570	0		5.00

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

	Related Organization(s) and/or Home Office	
	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	NOT-FOR PROFIT		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: 14-1304

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

Worksheet A-8-2

Date/Time Prepared:
11/19/2019 8:31 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	65.00	RESPIRATORY THERAPY	16,429	16,429	0	0	0	1.00
2.00	91.00	EMERGENCY	1,459,343	176,977	1,282,366	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,475,772	193,406	1,282,366			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	65.00	RESPIRATORY THERAPY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	65.00	RESPIRATORY THERAPY	0	0	0	16,429		1.00
2.00	91.00	EMERGENCY	0	0	0	176,977		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	193,406		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1304		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2019 8:31 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					48	1.00
2.00	Line 1 multiplied by 15 hours per week					720	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					219	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					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,187.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.61	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.31	38.31	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					90,936	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					90,936	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					90,936	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)					90,936	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)					8,390	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)					8,390	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)					1,295	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,595	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)					9,595	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1304		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/19/2019 8:31 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.61	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					90,936	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					9,595	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)					100,531	63.00
64.00	Total cost of outside supplier services (from your records)					55,350	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					8,390	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,205	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					9,595	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					1,205	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					1,205	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: 14-1304

Period:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	781,449	781,449			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	445,406		445,406		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	573,039	0	0	573,039	4.00
5.01	00570	ADMITTING	130,763	0	1,827	10,460	143,050
5.02	00590	HOSPITAL ONLY A & G	176,782	917	0	0	0
5.03	00591	SHARED ADMN & GENERAL	2,489,554	157,430	35,751	47,806	0
6.00	00600	MAINTENANCE & REPAIRS	500,173	71,803	14,531	8	0
8.00	00800	LAUNDRY & LINEN SERVICE	31,077	2,129	0	2,594	0
9.00	00900	HOUSEKEEPING	190,487	10,286	0	0	0
10.00	01000	DIETARY	64,337	32,560	3,570	0	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	1,654	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	39,408	27,434	4,893	1,496	0
16.00	01600	MEDICAL RECORDS & LIBRARY	155,807	3,571	0	0	0
17.00	01700	SOCIAL SERVICE	59,259	2,457	0	4,853	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	183,392	917	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,074,651	151,861	24,833	79,565	13,286
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	235,447	82,908	88,525	13,646	8,247
54.00	05400	RADIOLOGY-DIAGNOSTIC	793,461	71,328	202,646	40,981	39,570
60.00	06000	LABORATORY	973,009	27,745	3,259	39,668	30,117
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	23,617	0	0	475	361
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	244,154	5,208	8,037	18,830	3,990
66.00	06600	PHYSICAL THERAPY	370,990	32,380	11,353	21,464	7,915
67.00	06700	OCCUPATIONAL THERAPY	17,237	6,306	2,209	4,176	1,250
68.00	06800	SPEECH PATHOLOGY	608	229	78	147	94
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	62,134	0	0	0	1,981
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,824	0	0	0	273
73.00	07300	DRUGS CHARGED TO PATIENTS	472,751	9,696	315	11,468	11,063
76.00	03950	SLEEP LAB	26,252	13,840	3,035	1,725	1,687
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,143,835	0	1,882	162,041	0
91.00	09100	EMERGENCY	2,195,758	38,850	31,880	70,755	23,216
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,465,661	751,509	438,624	532,158	143,050
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,209	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	361,650	0	5,191	32,293	0
194.00	07950	RETAIL PHARMACY	342,651	0	1,591	8,588	0
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0
194.02	07952	KIDNEY CENTER	0	25,731	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		TOTAL (sum lines 118 through 201)	15,169,962	781,449	445,406	573,039	143,050

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

Period:
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Cost Center Description			Subtotal	HOSPITAL ONLY A & G	Subtotal	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			5A.01	5.02	5A.02	5.03	6.00	
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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	177,699	177,699				5.02
5.03	00591	SHARED ADMN & GENERAL	2,730,541	40,770	2,771,311	2,771,311		5.03
6.00	00600	MAINTENANCE & REPAIRS	586,515	8,756	595,271	133,330	728,601	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,800	534	36,334	8,138	2,426	8.00
9.00	00900	HOUSEKEEPING	200,773	2,997	203,770	45,641	11,722	9.00
10.00	01000	DIETARY	100,467	1,500	101,967	22,839	37,106	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,654	25	1,679	376	1,885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	73,231	1,093	74,324	16,647	31,264	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,378	2,379	161,757	36,231	4,069	16.00
17.00	01700	SOCIAL SERVICE	66,569	994	67,563	15,133	2,800	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	184,309	2,752	187,061	41,898	1,045	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,344,196	20,068	1,364,264	305,571	173,062	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	428,773	6,401	435,174	97,471	94,481	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,147,986	17,138	1,165,124	260,967	81,285	54.00
60.00	06000	LABORATORY	1,073,798	16,031	1,089,829	244,102	31,618	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	24,453	365	24,818	5,559	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	280,219	4,183	284,402	63,701	5,935	65.00
66.00	06600	PHYSICAL THERAPY	444,102	6,630	450,732	100,956	36,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,178	465	31,643	7,087	7,186	67.00
68.00	06800	SPEECH PATHOLOGY	1,156	17	1,173	263	261	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,115	957	65,072	14,575	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,097	166	11,263	2,523	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	505,293	7,544	512,837	114,866	11,050	73.00
76.00	03950	SLEEP LAB	46,539	695	47,234	10,580	15,772	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,307,758	0	2,307,758	516,896	100,342	88.00
91.00	09100	EMERGENCY	2,360,459	35,239	2,395,698	536,591	44,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,388,058	177,699	14,388,058	2,601,941	694,482	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4,209	0	4,209	943	4,797	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	399,134	0	399,134	89,399	0	192.00
194.00	07950	RETAIL PHARMACY	352,830	0	352,830	79,028	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	25,731	0	25,731	0	29,322	194.02
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)	15,169,962	177,699	15,169,962	2,771,311	728,601	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,898					8.00
9.00	00900	HOUSEKEEPING	0	261,133				9.00
10.00	01000	DIETARY	0	13,562	175,474			10.00
11.00	01100	CAFETERIA	0	0	131,931	131,931		11.00
13.00	01300	NURSING ADMINISTRATION	0	689	0	0	4,629	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,427	0	673	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,487	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,023	0	1,530	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	382	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,826	63,255	43,543	24,630	2,517	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,687	34,533	0	3,886	335	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,292	29,710	0	11,091	3	54.00
60.00	06000	LABORATORY	0	11,556	0	14,135	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	138	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,169	0	5,844	0	65.00
66.00	06600	PHYSICAL THERAPY	788	13,487	0	5,370	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	153	2,626	0	1,040	0	67.00
68.00	06800	SPEECH PATHOLOGY	6	96	0	31	0	68.00
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	4,039	0	3,534	0	73.00
76.00	03950	SLEEP LAB	23	5,765	0	505	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	347	36,675	0	33,685	0	88.00
91.00	09100	EMERGENCY	14,776	16,182	0	18,159	1,774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,898	248,663	175,474	124,251	4,629	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,753	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	7,680	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	10,717	0	0	0	194.02
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)	46,898	261,133	175,474	131,931	4,629	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			14.00	16.00	17.00	19.00	24.00	
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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	134,335					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	203,544				16.00
17.00	01700	SOCIAL SERVICE	0	0	88,049			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	230,386		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	15,971	18,904	88,049	0	2,122,592	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,969	11,735	0	230,386	923,657	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,210	56,305	0	0	1,626,987	54.00
60.00	06000	LABORATORY	1,928	42,853	0	0	1,436,021	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	513	0	0	31,028	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,882	5,678	0	0	375,611	65.00
66.00	06600	PHYSICAL THERAPY	3,730	11,262	0	0	623,225	66.00
67.00	06700	OCCUPATIONAL THERAPY	726	1,778	0	0	52,239	67.00
68.00	06800	SPEECH PATHOLOGY	26	134	0	0	1,990	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	34,935	2,819	0	0	117,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,086	388	0	0	20,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,319	15,741	0	0	663,386	73.00
76.00	03950	SLEEP LAB	2,099	2,400	0	0	84,378	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,449	0	0	0	3,006,152	88.00
91.00	09100	EMERGENCY	16,293	33,034	0	0	3,076,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	131,623	203,544	88,049	230,386	14,161,797	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	11,702	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,712	0	0	0	498,925	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	431,858	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	0	65,770	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	134,335	203,544	88,049	230,386	15,169,962	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
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11/19/2019 8:31 am

Cost Center Description			Intern & Residents Cost & Post Stepdown Adjustments	Total	
			25.00	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
5.01	00570	ADMITTING			5.01
5.02	00590	HOSPITAL ONLY A & G			5.02
5.03	00591	SHARED ADMN & GENERAL			5.03
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-176,144	1,946,448	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,460	927,117	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,626,987	54.00
60.00	06000	LABORATORY	0	1,436,021	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	31,028	63.00
64.00	06400	INTRAVENOUS THERAPY	172,684	172,684	64.00
65.00	06500	RESPIRATORY THERAPY	0	375,611	65.00
66.00	06600	PHYSICAL THERAPY	0	623,225	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	52,239	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,990	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	117,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	663,386	73.00
76.00	03950	SLEEP LAB	0	84,378	76.00
76.01	03951	DIABETIC EDUCATION	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	3,006,152	88.00
91.00	09100	EMERGENCY	0	3,076,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	14,161,707	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	11,702	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	498,925	192.00
194.00	07950	RETAIL PHARMACY	0	431,858	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	194.01
194.02	07952	KIDNEY CENTER	0	65,770	194.02
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	15,169,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	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	4.00
5.01	00570	ADMITTING	0	0	1,827	1,827	0 5.01
5.02	00590	HOSPITAL ONLY A & G	0	917	0	917	0 5.02
5.03	00591	SHARED ADMN & GENERAL	0	157,430	35,751	193,181	0 5.03
6.00	00600	MAINTENANCE & REPAIRS	0	71,803	14,531	86,334	0 6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,129	0	2,129	0 8.00
9.00	00900	HOUSEKEEPING	0	10,286	0	10,286	0 9.00
10.00	01000	DIETARY	0	32,560	3,570	36,130	0 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	1,654	0	1,654	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,434	4,893	32,327	0 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,571	0	3,571	0 16.00
17.00	01700	SOCIAL SERVICE	0	2,457	0	2,457	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	917	0	917	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	151,861	24,833	176,694	0 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	82,908	88,525	171,433	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,328	202,646	273,974	0 54.00
60.00	06000	LABORATORY	0	27,745	3,259	31,004	0 60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	5,208	8,037	13,245	0 65.00
66.00	06600	PHYSICAL THERAPY	0	32,380	11,353	43,733	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,306	2,209	8,515	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	229	78	307	0 68.00
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	9,696	315	10,011	0 73.00
76.00	03950	SLEEP LAB	0	13,840	3,035	16,875	0 76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0 76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	1,882	1,882	0 88.00
91.00	09100	EMERGENCY	0	38,850	31,880	70,730	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			0	0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	751,509	438,624	1,190,133	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,209	0	4,209	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	5,191	5,191	0 192.00
194.00	07950	RETAIL PHARMACY	0	0	1,591	1,591	0 194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0 194.01
194.02	07952	KIDNEY CENTER	0	25,731	0	25,731	0 194.02
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	781,449	445,406	1,226,855	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
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Cost Center Description			ADMITTING	HOSPITAL ONLY A & G	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	6.00	8.00	
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
5.01	00570	ADMITTING	1,827					5.01
5.02	00590	HOSPITAL ONLY A & G	0	917				5.02
5.03	00591	SHARED ADMN & GENERAL	0	210	193,391			5.03
6.00	00600	MAINTENANCE & REPAIRS	0	45	9,304	95,683		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3	568	319	3,019	8.00
9.00	00900	HOUSEKEEPING	0	15	3,185	1,539	0	9.00
10.00	01000	DIETARY	0	8	1,594	4,873	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	26	248	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6	1,162	4,106	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12	2,528	534	0	16.00
17.00	01700	SOCIAL SERVICE	0	5	1,056	368	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	14	2,924	137	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	170	104	21,323	22,727	1,471	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	106	33	6,802	12,408	237	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502	88	18,211	10,675	276	54.00
60.00	06000	LABORATORY	386	83	17,034	4,152	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	5	2	388	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	51	22	4,445	779	0	65.00
66.00	06600	PHYSICAL THERAPY	101	34	7,045	4,846	51	66.00
67.00	06700	OCCUPATIONAL THERAPY	16	2	495	944	10	67.00
68.00	06800	SPEECH PATHOLOGY	1	0	18	34	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25	5	1,017	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3	1	176	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	142	39	8,016	1,451	0	73.00
76.00	03950	SLEEP LAB	22	4	738	2,071	1	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	36,070	13,177	22	88.00
91.00	09100	EMERGENCY	297	182	37,447	5,814	951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,827	917	181,572	91,202	3,019	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	66	630	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	6,238	0	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	5,515	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	3,851	0	194.02
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)	1,827	917	193,391	95,683	3,019	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	15,025					9.00
10.00	01000	DIETARY	780	43,385				10.00
11.00	01100	CAFETERIA	0	32,619	32,619			11.00
13.00	01300	NURSING ADMINISTRATION	40	0	0	1,968		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	657	0	166	0	38,424	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	86	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	59	0	378	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	22	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,640	10,766	6,090	1,070	4,568	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,987	0	961	143	3,423	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,709	0	2,742	1	5,209	54.00
60.00	06000	LABORATORY	665	0	3,495	0	551	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	34	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	125	0	1,445	0	2,254	65.00
66.00	06600	PHYSICAL THERAPY	776	0	1,328	0	1,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	151	0	257	0	208	67.00
68.00	06800	SPEECH PATHOLOGY	5	0	8	0	7	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	9,994	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,741	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	232	0	874	0	377	73.00
76.00	03950	SLEEP LAB	332	0	125	0	600	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,110	0	8,327	0	2,989	88.00
91.00	09100	EMERGENCY	931	0	4,490	754	4,660	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,307	43,385	30,720	1,968	37,648	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	101	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,899	0	776	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	617	0	0	0	0	194.02
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)	15,025	43,385	32,619	1,968	38,424	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,731					16.00
17.00	01700	SOCIAL SERVICE	0	4,323				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	4,014			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	625	4,323		253,571	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	388	0		197,921	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,864	0		315,251	0	54.00
60.00	06000	LABORATORY	1,417	0		58,787	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	17	0		446	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	188	0		22,554	0	65.00
66.00	06600	PHYSICAL THERAPY	372	0		59,353	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	59	0		10,657	0	67.00
68.00	06800	SPEECH PATHOLOGY	4	0		384	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	93	0		11,134	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13	0		1,934	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	520	0		21,662	0	73.00
76.00	03950	SLEEP LAB	79	0		20,847	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0		0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0		64,577	0	88.00
91.00	09100	EMERGENCY	1,092	0		127,348	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,731	4,323	0	1,166,426	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		5,006	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		14,104	0	192.00
194.00	07950	RETAIL PHARMACY	0	0		7,106	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0		0	0	194.01
194.02	07952	KIDNEY CENTER	0	0		30,199	0	194.02
200.00		Cross Foot Adjustments			4,014	4,014	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,731	4,323	4,014	1,226,855	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/19/2019 8:31 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
5.01	00570	ADMITTING	5.01
5.02	00590	HOSPITAL ONLY A & G	5.02
5.03	00591	SHARED ADMN & GENERAL	5.03
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
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	SLEEP LAB	76.00
76.01	03951	DIABETIC EDUCATION	76.01
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	RETAIL PHARMACY	194.00
194.01	07951	NONPATIENT RELATED MEALS	194.01
194.02	07952	KIDNEY CENTER	194.02
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/19/2019 8:31 am

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	Reconciliation		
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00					4.00
	GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	47,712					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		450,421				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	6,384,662			4.00
5.01	00570	ADMITTING	0	1,848	116,544	21,293,616		5.01
5.02	00590	HOSPITAL ONLY A & G	56	0	0	0	-177,699	5.02
5.03	00591	SHARED ADMN & GENERAL	9,612	36,154	532,650	0	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	4,384	14,695	91	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	130	0	28,903	0	0	8.00
9.00	00900	HOUSEKEEPING	628	0	0	0	0	9.00
10.00	01000	DIETARY	1,988	3,610	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	4,948	16,671	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	0	54,066	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,272	25,113	886,498	1,977,656	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,062	89,522	152,042	1,227,642	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	204,926	456,608	5,890,400	0	54.00
60.00	06000	LABORATORY	1,694	3,296	441,974	4,483,014	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	5,291	53,670	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	318	8,127	209,802	593,969	0	65.00
66.00	06600	PHYSICAL THERAPY	1,977	11,481	239,151	1,178,127	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	385	2,234	46,531	185,994	0	67.00
68.00	06800	SPEECH PATHOLOGY	14	79	1,641	13,982	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	294,941	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,591	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	319	127,776	1,646,705	0	73.00
76.00	03950	SLEEP LAB	845	3,069	19,217	251,115	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,903	1,805,388	0	-2,307,758	88.00
91.00	09100	EMERGENCY	2,372	32,239	788,336	3,455,810	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,884	443,563	5,929,180	21,293,616	-2,485,457	118.00
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	257	0	0	0	-4,209	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,249	359,801	0	-399,134	192.00
194.00	07950	RETAIL PHARMACY	0	1,609	95,681	0	-352,830	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	1,571	0	0	0	-25,731	194.02
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)	781,449	445,406	573,039	143,050		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.378458	0.988866	0.089752	0.006718		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	1,827		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000086		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: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/19/2019 8:31 am

Cost Center Description		HOSPITAL ONLY A & G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.02	5A.03	5.03	6.00	8.00	
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
5.01	00570	ADMITTING					5.01
5.02	00590	HOSPITAL ONLY A & G	11,902,601				5.02
5.03	00591	SHARED ADMN & GENERAL	2,730,541	-2,771,311	12,372,920		5.03
6.00	00600	MAINTENANCE & REPAIRS	586,515	0	595,271	39,036	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	35,800	0	36,334	130	8.00
9.00	00900	HOUSEKEEPING	200,773	0	203,770	628	9.00
10.00	01000	DIETARY	100,467	0	101,967	1,988	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,654	0	1,679	101	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	73,231	0	74,324	1,675	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	159,378	0	161,757	218	16.00
17.00	01700	SOCIAL SERVICE	66,569	0	67,563	150	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	184,309	0	187,061	56	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,344,196	0	1,364,264	9,272	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	428,773	0	435,174	5,062	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,147,986	0	1,165,124	4,355	54.00
60.00	06000	LABORATORY	1,073,798	0	1,089,829	1,694	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	24,453	0	24,818	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	280,219	0	284,402	318	65.00
66.00	06600	PHYSICAL THERAPY	444,102	0	450,732	1,977	66.00
67.00	06700	OCCUPATIONAL THERAPY	31,178	0	31,643	385	67.00
68.00	06800	SPEECH PATHOLOGY	1,156	0	1,173	14	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	64,115	0	65,072	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,097	0	11,263	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	505,293	0	512,837	592	73.00
76.00	03950	SLEEP LAB	46,539	0	47,234	845	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	2,307,758	5,376	88.00
91.00	09100	EMERGENCY	2,360,459	0	2,395,698	2,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,902,601	-2,771,311	11,616,747	37,208	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	4,209	257	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	399,134	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	352,830	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	-25,731	0	1,571	194.02
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)	177,699		2,771,311	728,601	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.014929		0.223982	18.664848	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	917		193,391	95,683	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000077		0.015630	2.451148	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: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/19/2019 8:31 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (REQUIS.)	
			9.00	10.00	11.00	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
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	38,278					9.00
10.00	01000	DIETARY	1,988	23,704				10.00
11.00	01100	CAFETERIA	0	17,822	8,624			11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	56,966		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	0	44	0	238,909	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	0	100	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,272	5,882	1,610	30,977	28,403	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,062	0	254	4,127	21,286	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	0	725	33	32,385	54.00
60.00	06000	LABORATORY	1,694	0	924	0	3,428	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	9	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	318	0	382	0	14,017	65.00
66.00	06600	PHYSICAL THERAPY	1,977	0	351	0	6,634	66.00
67.00	06700	OCCUPATIONAL THERAPY	385	0	68	0	1,291	67.00
68.00	06800	SPEECH PATHOLOGY	14	0	2	0	46	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	62,134	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	0	231	0	2,346	73.00
76.00	03950	SLEEP LAB	845	0	33	0	3,733	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,376	0	2,202	0	18,583	88.00
91.00	09100	EMERGENCY	2,372	0	1,187	21,829	28,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00	11300	SUBTOTALS (SUM OF LINES 1 through 117)	36,450	23,704	8,122	56,966	234,086	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	257	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	502	0	4,823	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	0	0	194.01
194.02	07952	KIDNEY CENTER	1,571	0	0	0	0	194.02
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)	261,133	175,474	131,931	4,629	134,335	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.822013	7.402717	15.298122	0.081259	0.562285	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,025	43,385	32,619	1,968	38,424	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.392523	1.830282	3.782352	0.034547	0.160831	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: 14-1304

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

Worksheet B-1

Date/Time Prepared:
11/19/2019 8:31 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			16.00	17.00	19.00	
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
5.01	00570	ADMITTING				5.01
5.02	00590	HOSPITAL ONLY A & G				5.02
5.03	00591	SHARED ADMN & GENERAL				5.03
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,293,616			16.00
17.00	01700	SOCIAL SERVICE	0	146		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,977,656	146	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,227,642	0	100	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,890,400	0	0	54.00
60.00	06000	LABORATORY	4,483,014	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	53,670	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	593,969	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,178,127	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	185,994	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,982	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	294,941	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,591	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,646,705	0	0	73.00
76.00	03950	SLEEP LAB	251,115	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100	EMERGENCY	3,455,810	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,293,616	146	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	RETAIL PHARMACY	0	0	0	194.00
194.01	07951	NONPATIENT RELATED MEALS	0	0	0	194.01
194.02	07952	KIDNEY CENTER	0	0	0	194.02
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)	203,544	88,049	230,386	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009559	603.075342	2,303.860000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,731	4,323	4,014	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000316	29.609589	40.140000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

Provider CCN: 14-1304

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

Worksheet B-2

Date/Time Prepared:
11/19/2019 8:31 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00
7.00		IV THERAPY/RECOVERY ROOM		1	30.00	-176,144 7.00
8.00		RECOVERY ROOM		1	50.00	3,460 8.00
9.00		IV THERAPY		1	64.00	172,684 9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 8:31 am

				Title XVIII	Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,946,448		1,946,448	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	927,117		927,117	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,626,987		1,626,987	0	0	54.00
60.00	06000	LABORATORY	1,436,021		1,436,021	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	31,028		31,028	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	172,684		172,684	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	375,611	0	375,611	0	0	65.00
66.00	06600	PHYSICAL THERAPY	623,225	0	623,225	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,239	0	52,239	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,990	0	1,990	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	117,401		117,401	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,260		20,260	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	663,386		663,386	0	0	73.00
76.00	03950	SLEEP LAB	84,378		84,378	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0		0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,006,152		3,006,152	0	0	88.00
91.00	09100	EMERGENCY	3,076,780		3,076,780	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	420,819		420,819		0	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,582,526	0	14,582,526	0	0	200.00
201.00		Less Observation Beds	420,819		420,819		0	201.00
202.00		Total (see instructions)	14,161,707	0	14,161,707	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 8:31 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	1,012,373		1,012,373			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,290	1,225,352	1,227,642	0.755201	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	145,145	5,745,255	5,890,400	0.276210	0.000000	54.00
60.00	06000	LABORATORY	217,367	4,265,647	4,483,014	0.320325	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	10,939	42,731	53,670	0.578126	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	139,077	330,479	469,556	0.367760	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	118,853	475,116	593,969	0.632375	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	175,758	1,002,369	1,178,127	0.528996	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,649	70,345	185,994	0.280864	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,144	10,838	13,982	0.142326	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	114,550	180,391	294,941	0.398049	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,591	40,591	0.499125	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,983	1,328,722	1,646,705	0.402857	0.000000	73.00
76.00	03950	SLEEP LAB	0	251,115	251,115	0.336013	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0.000000	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,442,279	4,442,279			88.00
91.00	09100	EMERGENCY	59,685	3,396,125	3,455,810	0.890321	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,407	476,320	495,727	0.848893	0.000000	92.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	2,452,220	23,283,675	25,735,895			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	2,452,220	23,283,675	25,735,895			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 8:31 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
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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 SLEEP LAB	0.000000			76.00
76.01	03951 DIABETIC EDUCATION	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 8:31 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	1,946,448			1,946,448	0	1,946,448	30.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	927,117			927,117	0	927,117	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,626,987			1,626,987	0	1,626,987	54.00
60.00	06000	LABORATORY	1,436,021			1,436,021	0	1,436,021	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	31,028			31,028	0	31,028	63.00
64.00	06400	INTRAVENOUS THERAPY	172,684			172,684	0	172,684	64.00
65.00	06500	RESPIRATORY THERAPY	375,611	0		375,611	0	375,611	65.00
66.00	06600	PHYSICAL THERAPY	623,225	0		623,225	0	623,225	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,239	0		52,239	0	52,239	67.00
68.00	06800	SPEECH PATHOLOGY	1,990	0		1,990	0	1,990	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	117,401			117,401	0	117,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,260			20,260	0	20,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	663,386			663,386	0	663,386	73.00
76.00	03950	SLEEP LAB	84,378			84,378	0	84,378	76.00
76.01	03951	DIABETIC EDUCATION	0			0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,006,152			3,006,152	0	3,006,152	88.00
91.00	09100	EMERGENCY	3,076,780			3,076,780	0	3,076,780	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	420,819			420,819		420,819	92.00
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	14,582,526	0		14,582,526	0	14,582,526	200.00
201.00		Less Observation Beds	420,819			420,819		420,819	201.00
202.00		Total (see instructions)	14,161,707	0		14,161,707	0	14,161,707	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 8:31 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	1,012,373		1,012,373		30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,290	1,225,352	1,227,642	0.755201	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	145,145	5,745,255	5,890,400	0.276210	54.00
60.00	06000	LABORATORY	217,367	4,265,647	4,483,014	0.320325	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	10,939	42,731	53,670	0.578126	63.00
64.00	06400	INTRAVENOUS THERAPY	139,077	330,479	469,556	0.367760	64.00
65.00	06500	RESPIRATORY THERAPY	118,853	475,116	593,969	0.632375	65.00
66.00	06600	PHYSICAL THERAPY	175,758	1,002,369	1,178,127	0.528996	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,649	70,345	185,994	0.280864	67.00
68.00	06800	SPEECH PATHOLOGY	3,144	10,838	13,982	0.142326	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	114,550	180,391	294,941	0.398049	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	40,591	40,591	0.499125	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,983	1,328,722	1,646,705	0.402857	73.00
76.00	03950	SLEEP LAB	0	251,115	251,115	0.336013	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,442,279	4,442,279	0.676714	88.00
91.00	09100	EMERGENCY	59,685	3,396,125	3,455,810	0.890321	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,407	476,320	495,727	0.848893	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	2,452,220	23,283,675	25,735,895		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,452,220	23,283,675	25,735,895		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/19/2019 8:31 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
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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 SLEEP LAB	0.000000			76.00
76.01	03951 DIABETIC EDUCATION	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part II
Date/Time Prepared:
11/19/2019 8:31 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	197,921	1,227,642	0.161220	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	315,251	5,890,400	0.053519	52,218	2,795
60.00	06000	LABORATORY	58,787	4,483,014	0.013113	77,056	1,010
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	446	53,670	0.008310	4,381	36
64.00	06400	INTRAVENOUS THERAPY	0	469,556	0.000000	22,684	0
65.00	06500	RESPIRATORY THERAPY	22,554	593,969	0.037972	37,742	1,433
66.00	06600	PHYSICAL THERAPY	59,353	1,178,127	0.050379	3,753	189
67.00	06700	OCCUPATIONAL THERAPY	10,657	185,994	0.057298	2,526	145
68.00	06800	SPEECH PATHOLOGY	384	13,982	0.027464	609	17
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,134	294,941	0.037750	27,873	1,052
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,934	40,591	0.047646	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	21,662	1,646,705	0.013155	80,965	1,065
76.00	03950	SLEEP LAB	20,847	251,115	0.083018	0	0
76.01	03951	DIABETIC EDUCATION	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	64,577	4,442,279	0.014537	0	0
91.00	09100	EMERGENCY	127,348	3,455,810	0.036850	32,012	1,180
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	54,822	495,727	0.110589	14,577	1,612
200.00		Total (lines 50 through 199)	967,677	24,723,522		356,396	10,534

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/19/2019 8:31 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	230,386	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03950	SLEEP LAB	0	0	0	0	0
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
200.00		Total (lines 50 through 199)	230,386	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/19/2019 8:31 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	230,386	0	1,227,642	0.187665	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,890,400	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,483,014	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	53,670	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	469,556	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	593,969	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,178,127	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	185,994	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	13,982	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	294,941	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	40,591	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,646,705	0.000000	73.00
76.00	03950	SLEEP LAB	0	0	0	251,115	0.000000	76.00
76.01	03951	DIABETIC EDUCATION	0	0	0	0	0.000000	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,442,279	0.000000	88.00
91.00	09100	EMERGENCY	0	0	0	3,455,810	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	495,727	0.000000	92.00
200.00		Total (lines 50 through 199)	0	230,386	0	24,723,522		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/19/2019 8:31 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	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	52,218	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	77,056	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	4,381	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	22,684	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	37,742	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,753	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,526	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	609	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	27,873	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	80,965	0	0	0	73.00
76.00	03950	SLEEP LAB	0.000000	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
91.00	09100	EMERGENCY	0.000000	32,012	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	14,577	0	0	0	92.00
200.00		Total (lines 50 through 199)		356,396	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/19/2019 8:31 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	0.755201	0	315,874	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.276210	0	1,722,152	0	0	54.00
60.00	06000	LABORATORY	0.320325	0	1,371,724	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.578126	0	12,241	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.367760	0	132,581	360	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.632375	0	168,448	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.528996	0	320,438	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280864	0	11,681	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.142326	0	9,585	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.398049	0	64,928	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.499125	0	3,145	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402857	0	590,984	294	0	73.00
76.00	03950	SLEEP LAB	0.336013	0	86,052	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.890321	0	950,255	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848893	0	206,761	0	0	92.00
200.00		Subtotal (see instructions)		0	5,966,849	654	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	5,966,849	654	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/19/2019 8:31 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	238,548	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	475,676	0		54.00
60.00	06000	LABORATORY	439,397	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	7,077	0		63.00
64.00	06400	INTRAVENOUS THERAPY	48,758	132		64.00
65.00	06500	RESPIRATORY THERAPY	106,522	0		65.00
66.00	06600	PHYSICAL THERAPY	169,510	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,281	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,364	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,845	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,570	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	238,082	118		73.00
76.00	03950	SLEEP LAB	28,915	0		76.00
76.01	03951	DIABETIC EDUCATION	0	0		76.01
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	846,032	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	175,518	0		92.00
200.00		Subtotal (see instructions)	2,806,095	250		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,806,095	250		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1304

Period:

Worksheet D

Component CCN: 14-Z304

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/19/2019 8:31 am

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII		Swing Beds - SNF		Cost	
			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	0.755201	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.276210	0	0	0	0	54.00
60.00	06000	LABORATORY	0.320325	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.578126	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.367760	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.632375	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.528996	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280864	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.142326	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.398049	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.499125	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402857	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.336013	0	0	0	0	76.00
76.01	03951	DIABETIC EDUCATION	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.890321	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.848893	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			0	0		201.00
201.00		Only Charges						
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: 14-1304

Period:

Worksheet D

Component CCN: 14-Z304

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/19/2019 8:31 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	SLEEP LAB	0	0		76.00
76.01	03951	DIABETIC EDUCATION	0	0		76.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
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: 14-1304	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/19/2019 8:31 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,298	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			521	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)			246	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			373	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)			375	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			14	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)			15	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			155	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)			259	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)			261	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			155.41	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			158.52	20.00
21.00	Total general inpatient routine service cost (see instructions)			1,946,448	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)			2,176	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)			2,378	25.00
26.00	Total swing-bed cost (see instructions)			1,149,188	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			797,260	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)			797,260	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,530.26	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			237,190	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)			237,190	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1304

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

Worksheet D-1

Date/Time Prepared:
11/19/2019 8:31 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)					161,216	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					398,406	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)					396,337	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					399,398	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					795,735	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)					275	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,530.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					420,819	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1304

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

Worksheet D-1

Date/Time Prepared:
11/19/2019 8:31 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	253,571	1,946,448	0.130274	420,819	54,822
91.00	Nursing School cost	0	1,946,448	0.000000	420,819	0
92.00	Allied health cost	0	1,946,448	0.000000	420,819	0
93.00	All other Medical Education	0	1,946,448	0.000000	420,819	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1304	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/19/2019 8:31 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		170,878		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.755201	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.276210	52,218	14,423	54.00
60.00	06000 LABORATORY	0.320325	77,056	24,683	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.578126	4,381	2,533	63.00
64.00	06400 INTRAVENOUS THERAPY	0.367760	22,684	8,342	64.00
65.00	06500 RESPIRATORY THERAPY	0.632375	37,742	23,867	65.00
66.00	06600 PHYSICAL THERAPY	0.528996	3,753	1,985	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.280864	2,526	709	67.00
68.00	06800 SPEECH PATHOLOGY	0.142326	609	87	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.398049	27,873	11,095	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.499125		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.402857	80,965	32,617	73.00
76.00	03950 SLEEP LAB	0.336013	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.000000	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.890321	32,012	28,501	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.848893	14,577	12,374	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		356,396	161,216	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)		356,396		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1304 Component CCN: 14-Z304	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/19/2019 8:31 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	0.755201	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.276210	23,022	6,359	54.00
60.00	06000 LABORATORY	0.320325	57,079	18,284	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.578126	3,350	1,937	63.00
64.00	06400 INTRAVENOUS THERAPY	0.367760	62,826	23,105	64.00
65.00	06500 RESPIRATORY THERAPY	0.632375	39,012	24,670	65.00
66.00	06600 PHYSICAL THERAPY	0.528996	111,003	58,720	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.280864	74,041	20,795	67.00
68.00	06800 SPEECH PATHOLOGY	0.142326	2,014	287	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.398049	47,130	18,760	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.499125	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.402857	122,913	49,516	73.00
76.00	03950 SLEEP LAB	0.336013	0	0	76.00
76.01	03951 DIABETIC EDUCATION	0.000000	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.890321	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.848893	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		542,390	222,433	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		542,390		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1304	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/19/2019 8:31 am
		Title XVIII	Hospital	Cost
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,806,345	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,806,345	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,834,408	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)		26,594	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		911,203	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,896,611	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,896,611	30.00
31.00	Primary payer payments		1,756	31.00
32.00	Subtotal (line 30 minus line 31)		1,894,855	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)		79,549	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		51,707	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		64,437	36.00
37.00	Subtotal (see instructions)		1,946,562	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)		1,946,562	40.00
40.01	Sequestration adjustment (see instructions)		38,931	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,662,492	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		245,139	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/19/2019 8:31 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		293,612		1,686,854	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	02/01/2019	4,998	02/01/2019	24,362	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)		-4,998		-24,362	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)		288,614		1,662,492	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		59,507		245,139	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		348,121		1,907,631	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1304

Period:

Worksheet E-1

Component CCN: 14-Z304

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/19/2019 8:31 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		961,504		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		961,504		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		35,138		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		996,642		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part II
Date/Time Prepared:
11/19/2019 8:31 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: 14-1304 Component CCN: 14-Z304	Period: From 07/01/2018 To 06/30/2019	Worksheet E-2 Date/Time Prepared: 11/19/2019 8:31 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)	803,692	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)	224,657	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	520	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,028,349	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,028,349	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,028,349	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,367	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,016,982	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,016,982	0	19.00
19.01	Sequestration adjustment (see instructions)	20,340	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	961,504	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)	35,138	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1304	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/19/2019 8:31 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		398,406	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)		398,406	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		402,390	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)		402,390	19.00
20.00	Deductibles (exclude professional component)		54,062	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		348,328	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		348,328	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		10,612	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		6,898	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,748	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		355,226	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)		355,226	30.00
30.01	Sequestration adjustment (see instructions)		7,105	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		288,614	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)		59,507	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

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

Provider CCN: 14-1304

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

Worksheet G

Date/Time Prepared:

11/19/2019 8:31 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	52,753	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	5,138,628	0	0	0	4.00
5.00 Other receivable	4,805	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-2,559,485	0	0	0	6.00
7.00 Inventory	134,932	0	0	0	7.00
8.00 Prepaid expenses	51,895	0	0	0	8.00
9.00 Other current assets	815,087	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)	3,638,615	0	0	0	11.00
FIXED ASSETS					
12.00 Land	65,000	0	0	0	12.00
13.00 Land improvements	326,868	0	0	0	13.00
14.00 Accumulated depreciation	-116,590	0	0	0	14.00
15.00 Buildings	12,900,883	0	0	0	15.00
16.00 Accumulated depreciation	-3,401,742	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	3,167,769	0	0	0	19.00
20.00 Accumulated depreciation	-1,532,491	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	109,793	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	11,519,490	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	1,390,428	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	570,341	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	1,960,769	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	17,118,874	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	87,723	0	0	0	37.00
38.00 Salaries, wages, and fees payable	393,674	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	7,237,287	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	284,679	0	0	0	43.00
44.00 Other current liabilities	87,465	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	8,090,828	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	5,189,395	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	5,189,395	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	13,280,223	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	3,838,651				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)	3,838,651	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	17,118,874	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1304

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

Worksheet G-1

Date/Time Prepared:
11/19/2019 8:31 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		4,834,811		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,239,719				2.00
3.00	Total (sum of line 1 and line 2)		3,595,092		0		3.00
4.00	Additions (credit adjustments)	243,559		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		243,559		0		10.00
11.00	Subtotal (line 3 plus line 10)		3,838,651		0		11.00
12.00	OTHER	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)		3,838,651		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	OTHER		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: 14-1304

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/19/2019 8:31 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,996,992		1,996,992	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,996,992		1,996,992	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)	1,996,992		1,996,992	17.00
18.00	Ancillary services	1,307,612	19,936,451	21,244,063	18.00
19.00	Outpatient services	0	1,325,319	1,325,319	19.00
20.00	RURAL HEALTH CLINIC	63,471	4,378,808	4,442,279	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	OTHER (SPECIFY)	0	0	0	27.01
27.02	OTHER (SPECIFY)	0	0	0	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,368,075	25,640,578	29,008,653	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,705,339		29.00
30.00	OTHER EXPENSES - BAD DEBTS	14,412			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)		14,412		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)		16,719,751		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1304

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

Worksheet G-3

Date/Time Prepared:
11/19/2019 8:31 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	29,008,653	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,916,006	2.00
3.00	Net patient revenues (line 1 minus line 2)	14,092,647	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,719,751	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,627,104	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	63	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	95,691	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	2,040	22.00
23.00	Governmental appropriations	40,000	23.00
24.00	MISC INCOME	78,834	24.00
24.01	ADMINISTRATION INCOME	1,170,757	24.01
25.00	Total other income (sum of lines 6-24)	1,387,385	25.00
26.00	Total (line 5 plus line 25)	-1,239,719	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,239,719	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304

Period:

Worksheet M-1

Component CCN: 14-3453

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/19/2019 8:31 am

		RHC I		Cost		
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	620,629	39,723	660,352	0	660,352 1.00
2.00	Physician Assistant	0	0	0	0	0 2.00
3.00	Nurse Practitioner	495,491	31,713	527,204	0	527,204 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	274,713	17,583	292,296	0	292,296 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	65,440	4,188	69,628	0	69,628 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	237,098	15,175	252,273	0	252,273 9.00
10.00	Subtotal (sum of lines 1 through 9)	1,693,371	108,382	1,801,753	0	1,801,753 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	13,750	13,750	0	13,750 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	13,750	13,750	0	13,750 14.00
15.00	Medical Supplies	0	20,406	20,406	17,091	37,497 15.00
16.00	Transportation (Health Care Staff)	0	2,071	2,071	0	2,071 16.00
17.00	Depreciation-Medical Equipment	0	7,162	7,162	0	7,162 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	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	29,639	29,639	17,091	46,730 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,693,371	151,771	1,845,142	17,091	1,862,233 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	35,618	35,618	-17,091	18,527 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	35,618	35,618	-17,091	18,527 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	84,829	84,829	-5,847	78,982 29.00
30.00	Administrative Costs	338,307	167,718	506,025	-240,839	265,186 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	338,307	252,547	590,854	-246,686	344,168 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,031,678	439,936	2,471,614	-246,686	2,224,928 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1304

Period:

Worksheet M-1

Component CCN: 14-3453

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/19/2019 8:31 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	660,352	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	527,204	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	292,296	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	69,628	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	252,273	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,801,753	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	13,750	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	13,750	14.00
15.00	Medical Supplies	0	37,497	15.00
16.00	Transportation (Health Care Staff)	0	2,071	16.00
17.00	Depreciation-Medical Equipment	0	7,162	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	46,730	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,862,233	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	18,527	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	18,527	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	78,982	29.00
30.00	Administrative Costs	-81,093	184,093	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-81,093	263,075	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-81,093	2,143,835	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1304

Period:

Worksheet M-2

Component CCN: 14-3453

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/19/2019 8:31 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	2.28	9,290	4,200	9,576		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.71	10,770	2,100	7,791		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.99	20,060		17,367	20,060	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	0.91	1,767			1,767	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.90	21,827			21,827	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)					1,862,233	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					18,527	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,880,760	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.990149	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					263,075	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					862,317	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,125,392	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,125,392	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,114,306	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,976,539	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/19/2019 8:31 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			2,976,539	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			26,904	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,949,635	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,827	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)			21,827	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			135.14	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	84.70	8.00
9.00	Rate for Program covered visits (see instructions)		135.14	135.14	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	4,041	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	546,101	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	546,101	16.00
16.01	Total program charges (see instructions)(from contractor's records)			869,247	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			7,538	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			4,736	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.)			392,166	16.04
16.05	Total program cost (see instructions)		0	396,902	16.05
17.00	Primary payer amounts			228	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			51,157	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			163,618	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			396,674	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			1,440	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			398,114	22.00
23.00	Allowable bad debts (see instructions)			0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			398,114	26.00
26.01	Sequestration adjustment (see instructions)			7,962	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			388,973	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)			1,179	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: 14-1304 Component CCN: 14-3453	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/19/2019 8:31 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)		1,801,753	1,801,753	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.002840	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	5,117	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	11,715	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	16,832	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,862,233	1,862,233	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,114,306	1,114,306	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.009039	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	10,072	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	26,904	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	299	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	89.98	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	16	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	1,440	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)			26,904	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			1,440	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1304 Component CCN: 14-3453	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/19/2019 8:31 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		377,130	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		02/17/2019	11,843	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)		11,843	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		388,973	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		1,179	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		390,152	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00