

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1308	Period: From 05/01/2018 To 04/30/2019	Worksheet S Parts I-III Date/Time Prepared: 9/24/2019 8:12 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 9/24/2019	Time: 8:12 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 WASHINGTON COUNTY HOSPITAL (14-1308) for the cost reporting period beginning 05/01/2018 and ending 04/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	31,744	-368,271	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	72,557	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		17,932		0	10.00
200.00	Total	0	104,301	-350,339	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: 14-1308		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/24/2019 8:12 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 705 SOUTH GRAND AVENUE			PO Box:				1.00		
2.00	City: NASHVILLE			State: IL		Zip Code: 62263		County: WASHINGTON		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
								XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		WASHINGTON COUNTY HOSPITAL	141308	99914	1	12/01/2000	N	O	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		WASHINGTON COUNTY SWING BED	14Z308	99914		08/18/2000	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC		WASHINGTON COUNTY EXTENDED CARE							
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		GRAND STREET RHC	143472	99914		08/01/2005	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)						05/01/2018	04/30/2019		
21.00	Type of Control (see instructions)						11			
							1.00	2.00		
							2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part I
Date/Time Prepared:
9/24/2019 8:12 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 OPSS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1308		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/24/2019 8:12 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			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part I
Date/Time Prepared:
9/24/2019 8:12 am

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

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				1.00				
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.06		
Rural Providers								
105.00	Does this hospital qualify as a CAH?			Y		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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	N	N	N	109.00
						1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00

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			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	39,595	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1308		Period: From 05/01/2018 To 04/30/2019		Worksheet S-2 Part I Date/Time Prepared: 9/24/2019 8:12 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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)					05/01/2018	04/30/2019		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1308	Period: From 05/01/2018 To 04/30/2019	Worksheet S-2 Part II Date/Time Prepared: 9/24/2019 8:12 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/15/2019	17.00
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		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
Date/Time Prepared:
9/24/2019 8:12 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.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VALERIE	TEPE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WASHINGTON COUNTY HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-327-2303	VTEPE@WASHINGTONCOUNTYHOSPITAL.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet S-2
Part II
Date/Time Prepared:
9/24/2019 8:12 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.	ACCOUNTING MANAGER	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: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/24/2019 8:12 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	3,543.00	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	3,543.00	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	3,543.00	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	46.00	28	10,220			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	115.00					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)		50				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: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/24/2019 8:12 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)	144	6	201			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,211	0	1,310			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	314			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,355	6	1,825			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)	1,355	6	1,825	0.00	89.03	14.00
15.00	CAH visits	9,326	504	25,579			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			8,039	0.00	16.27	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	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	2,986	0	9,777	0.00	12.75	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	118.05	27.00
28.00	Observation Bed Days		0	37			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: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet S-3
Part I
Date/Time Prepared:
9/24/2019 8:12 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	52	2	68	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	52	2	68	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	0.00				25	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)	0.00					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

Health Financial Systems		WASHINGTON COUNTY HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1308 Component CCN: 14-3472		Period: From 05/01/2018 To 04/30/2019 Worksheet S-8 Date/Time Prepared: 9/24/2019 8:12 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	705 SOUTH GRAND AVE		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	NASHVILLE		IL 62263	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
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	07:30		19:00	07:30
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	WASHINGTON		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	19:00	07:30	19:00	07:30
		19:00	07:30	19:00	07:30

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1308

Period:

Worksheet S-8

Component CCN: 14-3472

From 05/01/2018
To 04/30/2019Date/Time Prepared:
9/24/2019 8:12 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1) CLINIC	07:30	19:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1308

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

Worksheet S-10

Date/Time Prepared:
9/24/2019 8:12 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)		0.640815	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,105,655	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		2,299,390	6.00
7.00	Medicaid cost (line 1 times line 6)		1,473,484	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)		367,829	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		367,829	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	43,379	58,619	101,998
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	27,798	58,619	86,417
22.00	Payments received from patients for amounts previously written off as charity care	390	907	1,297
23.00	Cost of charity care (line 21 minus line 22)	27,408	57,712	85,120
			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)		602,248	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		79,996	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		123,072	27.01
28.00	Non-Medicare bad debt expense (see instructions)		479,176	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		350,139	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		435,259	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		803,088	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1308

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

Worksheet A

Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		222,938	222,938	34,386	257,324	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		135,248	135,248	0	135,248	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,246	1,820,253	1,841,499	0	1,841,499	4.00
5.01	00550	INFORMATION SYSTEMS	210,254	280,177	490,431	-42,999	447,432	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	480,315	882,289	1,362,604	39,997	1,402,601	5.02
6.00	00600	MAINTENANCE & REPAIRS	102,598	447,119	549,717	0	549,717	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	128,149	128,149	0	128,149	8.00
9.00	00900	HOUSEKEEPING	186,739	22,647	209,386	0	209,386	9.00
10.00	01000	DIETARY	231,535	124,127	355,662	-23,224	332,438	10.00
11.00	01100	CAFETERIA	0	0	0	23,224	23,224	11.00
13.00	01300	NURSING ADMINISTRATION	1,994	342	2,336	0	2,336	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,186	16,822	75,008	0	75,008	14.00
15.00	01500	PHARMACY	131,956	32,178	164,134	0	164,134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	178,385	24,730	203,115	0	203,115	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	5,617	5,617	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	67,800	67,800	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	665,888	118,154	784,042	-5,617	778,425	30.00
46.00	04600	OTHER LONG TERM CARE	532,294	24,032	556,326	0	556,326	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	133,931	100,135	234,066	0	234,066	50.00
53.00	05300	ANESTHESIOLOGY	0	76,849	76,849	-67,800	9,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	272,526	267,098	539,624	42,999	582,623	54.00
60.00	06000	LABORATORY	389,660	574,696	964,356	0	964,356	60.00
65.00	06500	RESPIRATORY THERAPY	1,009	31,438	32,447	0	32,447	65.00
66.00	06600	PHYSICAL THERAPY	802,443	38,168	840,611	0	840,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	58,797	7,088	65,885	0	65,885	68.01
69.00	06900	ELECTROCARDIOLOGY	6,778	9,024	15,802	0	15,802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	54,814	54,814	-10,132	44,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,132	10,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	734,683	734,683	0	734,683	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,075,003	390,029	1,465,032	-39,997	1,425,035	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	459,558	1,052,072	1,511,630	0	1,511,630	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	34,475	34,475	-34,475	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,001,095	7,649,774	13,650,869	-89	13,650,780	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,176	8,176	89	8,265	190.00
190.01	19001	OUTPATIENT CLINIC	12,809	189	12,998	0	12,998	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	6,013,904	7,658,139	13,672,043	0	13,672,043	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1308

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

Worksheet A

Date/Time Prepared:
9/24/2019 8:12 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	257,324	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-9,118	126,130	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,841,499	4.00
5.01	00550	INFORMATION SYSTEMS	0	447,432	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	-16,158	1,386,443	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	549,717	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	128,149	8.00
9.00	00900	HOUSEKEEPING	0	209,386	9.00
10.00	01000	DIETARY	0	332,438	10.00
11.00	01100	CAFETERIA	-13,232	9,992	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,336	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-174	74,834	14.00
15.00	01500	PHARMACY	0	164,134	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,869	195,246	16.00
17.00	01700	SOCIAL SERVICE	0	5,617	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	67,800	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	778,425	30.00
46.00	04600	OTHER LONG TERM CARE	0	556,326	46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	234,066	50.00
53.00	05300	ANESTHESIOLOGY	0	9,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,861	579,762	54.00
60.00	06000	LABORATORY	0	964,356	60.00
65.00	06500	RESPIRATORY THERAPY	0	32,447	65.00
66.00	06600	PHYSICAL THERAPY	0	840,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	CARDIAC REHAB	0	65,885	68.01
69.00	06900	ELECTROCARDIOLOGY	-8,846	6,956	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,132	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-52,834	681,849	73.00
76.00	03480	ONCOLOGY	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-147,723	1,277,312	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-140,386	1,371,244	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-399,201	13,251,579	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,265	190.00
190.01	19001	OUTPATIENT CLINIC	0	12,998	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-399,201	13,272,842	200.00

RECLASSIFICATIONS

Provider CCN: 14-1308

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

Worksheet A-6

Date/Time Prepared:
9/24/2019 8:12 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - RECLASSIFY CAFETERIA COSTS					
	CAFETERIA	11.00	15,119	8,105		1.00
	TOTALS		15,119	8,105		
1.00	B - RECLASS SOCIAL SERVICE COST					
	SOCIAL SERVICE	17.00	5,617	0		1.00
	TOTALS		5,617	0		
1.00	C - RECLASS PROFESSIONAL LIABILITY INSUR					
	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	39,997		1.00
	TOTALS		0	39,997		
1.00	D - RECLASSIFY XRAY DIRECTORS SALARY					
	RADIOLOGY-DIAGNOSTIC	54.00	42,999	0		1.00
	TOTALS		42,999	0		
1.00	E - RECLASSIFY ANESTHESIA PRO FEES					
	NONPHYSICIAN ANESTHETISTS	19.00	0	67,800		1.00
	TOTALS		0	67,800		
1.00	F - INTEREST EXPENSE					
	CAP REL COSTS-BLDG & FIXT	1.00	0	34,475		1.00
	TOTALS		0	34,475		
1.00	G - TO RECLASS INTEROCULAR LENS					
	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,132		1.00
	TOTALS		0	10,132		
1.00	H - TO RECLASS ANNEX BLDG DEPRECIATION					
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	89		1.00
	TOTALS		0	89		
500.00	Grand Total: Increases		63,735	160,598		500.00

RECLASSIFICATIONS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet A-6
Date/Time Prepared:
9/24/2019 8:12 am

		Decreases				wkst. A-7 Ref.		
		Cost Center	Line #	Salary	Other			
		6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY CAFETERIA COSTS							
1.00	DIETARY		10.00	15,119	8,105	0		1.00
	TOTALS			15,119	8,105			
	B - RECLASS SOCIAL SERVICE COST							
1.00	ADULTS & PEDIATRICS		30.00	5,617	0	0		1.00
	TOTALS			5,617	0			
	C - RECLASS PROFESSIONAL LIABILITY INSUR							
1.00	RURAL HEALTH CLINIC		88.00	0	39,997	0		1.00
	TOTALS			0	39,997			
	D - RECLASSIFY XRAY DIRECTORS SALARY							
1.00	INFORMATION SYSTEMS		5.01	42,999	0	0		1.00
	TOTALS			42,999	0			
	E - RECLASSIFY ANESTHESIA PRO FEES							
1.00	ANESTHESIOLOGY		53.00	0	67,800	0		1.00
	TOTALS			0	67,800			
	F - INTEREST EXPENSE							
1.00	INTEREST EXPENSE		113.00	0	34,475	9		1.00
	TOTALS			0	34,475			
	G - TO RECLASS INTEROCULAR LENS							
1.00	MEDICAL SUPPLIES CHARGED TO		71.00	0	10,132	0		1.00
	PATIENTS							
	TOTALS			0	10,132			
	H - TO RECLASS ANNEX BLDG DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	89	9		1.00
	TOTALS			0	89			
500.00	Grand Total: Decreases			63,735	160,598			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part I
Date/Time Prepared:
9/24/2019 8:12 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	62,855	0	0	0	0	1.00	
2.00	Land Improvements	419,030	0	0	0	0	2.00	
3.00	Buildings and Fixtures	9,482,503	33,444	0	33,444	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	5,241,374	76,091	0	76,091	0	6.00	
7.00	HIT designated Assets	927,041	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	16,132,803	109,535	0	109,535	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	16,132,803	109,535	0	109,535	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	62,855	0				1.00	
2.00	Land Improvements	419,030	0				2.00	
3.00	Buildings and Fixtures	9,515,947	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	5,317,465	0				6.00	
7.00	HIT designated Assets	927,041	0				7.00	
8.00	Subtotal (sum of lines 1-7)	16,242,338	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	16,242,338	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part II
Date/Time Prepared:
9/24/2019 8:12 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	222,938	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	135,248	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	358,186	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	222,938				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	135,248				2.00
3.00	Total (sum of lines 1-2)	0	358,186				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet A-7
Part III
Date/Time Prepared:
9/24/2019 8:12 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	9,997,832	0	9,997,832	0.615541	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,244,506	0	6,244,506	0.384459	0	2.00
3.00	Total (sum of lines 1-2)	16,242,338	0	16,242,338	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	257,324	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	126,130	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	383,454	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	0	0	0	257,324	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	126,130	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	383,454	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1308

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

Worksheet A-8

Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			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)	B	-13,582	0OTHER ADMINISTRATIVE AND GENERAL	5.02	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-174	0CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-152,093			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	0	0RADIOLOGY-DIAGNOSTIC	54.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-13,232	0CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-7,869	0MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0	0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-9,118	0CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1308

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

Worksheet A-8

Date/Time Prepared:
9/24/2019 8:12 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 ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	MISCELLANEOUS REVENUE - OTHER	B	-377	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.01
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
35.00	EDUCATION FEES	B	-240	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	NONALLOWABLE PUBLIC RELATIONS	A	-5,104	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	HEALTHLINK ADMIN FEES	A	21,857	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	LOBBYING PORTION OF DUES	A	-9,789	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38.00
39.00	NON-RHC SERVICES	A	-142,741	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	NON-RHC BENEFITS	A	-4,982	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	TELEPHONE SERVICE	B	-8,923	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	340B PHARMACY	A	-52,834	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-399,201				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1308

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

Worksheet A-8-2

Date/Time Prepared:
9/24/2019 8:12 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	54.00	RADIOLOGY-DIAGNOSTIC	2,861	2,861	0	0	0	1.00
2.00	60.00	LABORATORY	20,150	0	20,150	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	8,846	8,846	0	0	0	3.00
4.00	91.00	EMERGENCY	1,011,684	140,386	871,298	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	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			1,043,541	152,093	891,448		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,861		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	8,846		3.00
4.00	91.00	EMERGENCY	0	0	0	140,386		4.00
5.00	65.00	RESPIRATORY THERAPY	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	152,093		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	INFORMATION SYSTEMS	
			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	257,324	257,324			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	126,130		126,130		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,841,499	659	0	1,842,158	4.00
5.01	00550	INFORMATION SYSTEMS	447,432	4,600	2,873	51,415	506,320 5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,386,443	23,057	914	147,650	90,272 5.02
6.00	00600	MAINTENANCE & REPAIRS	549,717	42,155	207	31,539	7,850 6.00
8.00	00800	LAUNDRY & LINEN SERVICE	128,149	2,994	0	0	0 8.00
9.00	00900	HOUSEKEEPING	209,386	1,958	0	57,404	7,850 9.00
10.00	01000	DIETARY	332,438	11,970	584	66,527	11,775 10.00
11.00	01100	CAFETERIA	9,992	3,633	0	4,648	0 11.00
13.00	01300	NURSING ADMINISTRATION	2,336	2,602	0	613	3,925 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,834	3,990	6,303	17,886	7,850 14.00
15.00	01500	PHARMACY	164,134	4,337	14,255	40,564	15,700 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	195,246	4,877	19	54,836	23,550 16.00
17.00	01700	SOCIAL SERVICE	5,617	416	0	1,727	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	67,800	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	778,425	24,044	7,522	202,969	47,100 30.00
46.00	04600	OTHER LONG TERM CARE	556,326	27,944	1,762	163,628	15,700 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	234,066	16,480	2,930	41,171	19,625 50.00
53.00	05300	ANESTHESIOLOGY	9,049	0	2,470	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	579,762	14,726	58,378	96,993	47,100 54.00
60.00	06000	LABORATORY	964,356	9,204	1,570	119,782	19,625 60.00
65.00	06500	RESPIRATORY THERAPY	32,447	491	2,865	310	0 65.00
66.00	06600	PHYSICAL THERAPY	840,611	12,619	5,917	246,673	62,799 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
68.01	06801	CARDIAC REHAB	65,885	2,012	10,289	18,074	3,925 68.01
69.00	06900	ELECTROCARDIOLOGY	6,956	238	1,785	2,084	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,682	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,132	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	681,849	0	0	0	0 73.00
76.00	03480	ONCOLOGY	0	0	0	0	3,925 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,277,312	17,734	48	330,458	74,574 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	1,371,244	13,174	5,439	141,269	23,550 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0 113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,251,579	245,914	126,130	1,838,220	486,695 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,265	0	0	0	0 190.00
190.01	19001	OUTPATIENT CLINIC	12,998	11,410	0	3,938	19,625 190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0 190.02
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
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)	13,272,842	257,324	126,130	1,842,158	506,320 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description			Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	6.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,648,336	1,648,336				5.02
6.00	00600	MAINTENANCE & REPAIRS	631,468	89,541	721,009			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	131,143	18,596	11,552	161,291		8.00
9.00	00900	HOUSEKEEPING	276,598	39,221	7,555	0	323,374	9.00
10.00	01000	DIETARY	423,294	60,022	46,188	0	21,279	10.00
11.00	01100	CAFETERIA	18,273	2,591	14,019	0	6,459	11.00
13.00	01300	NURSING ADMINISTRATION	9,476	1,344	10,041	0	4,626	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	110,863	15,720	15,396	0	7,093	14.00
15.00	01500	PHARMACY	238,990	33,888	16,735	0	7,710	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	278,528	39,495	18,819	0	8,670	16.00
17.00	01700	SOCIAL SERVICE	7,760	1,100	1,607	0	740	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	67,800	9,614	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,060,060	150,314	92,777	21,258	42,744	30.00
46.00	04600	OTHER LONG TERM CARE	765,360	108,527	107,828	115,559	49,677	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	314,272	44,563	63,592	3,076	29,298	50.00
53.00	05300	ANESTHESIOLOGY	11,519	1,633	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	796,959	113,007	56,822	3,824	26,178	54.00
60.00	06000	LABORATORY	1,114,537	158,039	35,516	0	16,363	60.00
65.00	06500	RESPIRATORY THERAPY	36,113	5,121	1,893	0	872	65.00
66.00	06600	PHYSICAL THERAPY	1,168,619	165,708	48,693	8,782	22,434	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	100,185	14,206	7,765	0	3,577	68.01
69.00	06900	ELECTROCARDIOLOGY	11,063	1,569	918	0	423	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,682	6,336	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,132	1,437	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	681,849	96,685	0	0	0	73.00
76.00	03480	ONCOLOGY	3,925	557	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,700,126	241,078	68,431	254	31,527	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,554,676	220,450	50,835	7,763	23,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,216,606	1,640,362	676,982	160,516	303,090	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,265	1,172	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	47,971	6,802	44,027	775	20,284	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	13,272,842	1,648,336	721,009	161,291	323,374	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	550,783					10.00
11.00	01100	CAFETERIA	0	41,342				11.00
13.00	01300	NURSING ADMINISTRATION	0	15	25,502			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	780	0	149,852		14.00
15.00	01500	PHARMACY	0	527	0	60	297,910	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,951	0	120	0	16.00
17.00	01700	SOCIAL SERVICE	0	49	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	113,188	5,710	7,524	28,013	369	30.00
46.00	04600	OTHER LONG TERM CARE	434,715	7,934	10,065	18,342	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,068	1,390	15,653	1	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,021	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,467	0	3,187	155	54.00
60.00	06000	LABORATORY	0	3,570	0	2,550	95	60.00
65.00	06500	RESPIRATORY THERAPY	0	5	9	2,634	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,017	0	1,463	582	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	483	607	889	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	63	89	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	31,076	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,563	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	292,863	73.00
76.00	03480	ONCOLOGY	0	0	0	5	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	6,217	0	3,462	158	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	4,379	5,665	24,781	3,686	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	547,903	41,235	25,349	149,819	297,910	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	107	153	33	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	2,880	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	550,783	41,342	25,502	149,852	297,910	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/24/2019 8:12 am

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	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	347,583					16.00
17.00	01700	SOCIAL SERVICE	0	11,256				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	77,414			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,593	10,130	0	1,550,680	-45,747	30.00
46.00	04600	OTHER LONG TERM CARE	19,966	1,126	0	1,639,099	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	23,213	0	0	496,126	0	50.00
53.00	05300	ANESTHESIOLOGY	1,071	0	77,414	95,659	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,354	0	0	1,091,953	0	54.00
60.00	06000	LABORATORY	70,791	0	0	1,401,461	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,498	0	0	48,145	0	65.00
66.00	06600	PHYSICAL THERAPY	45,243	0	0	1,467,541	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	2,861	0	0	130,573	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,526	0	0	17,651	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,357	0	0	83,451	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	430	0	0	25,562	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,698	0	0	1,097,095	0	73.00
76.00	03480	ONCOLOGY	611	0	0	5,098	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	19,137	0	0	2,070,390	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	24,234	0	0	1,919,889	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	45,747	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	347,583	11,256	77,414	13,140,373	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	9,437	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	0	120,152	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	2,880	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	347,583	11,256	77,414	13,272,842	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part I
Date/Time Prepared:
9/24/2019 8:12 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	00550	INFORMATION SYSTEMS	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	5.02
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
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
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
68.01	06801	CARDIAC REHAB	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03480	ONCOLOGY	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	OUTPATIENT CLINIC	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	190.02
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/24/2019 8:12 am

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	659	0	659	4.00
5.01	00550	INFORMATION SYSTEMS	0	4,600	2,873	7,473	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	0	23,057	914	23,971	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	42,155	207	42,362	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,994	0	2,994	8.00
9.00	00900	HOUSEKEEPING	0	1,958	0	1,958	9.00
10.00	01000	DIETARY	0	11,970	584	12,554	10.00
11.00	01100	CAFETERIA	0	3,633	0	3,633	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,602	0	2,602	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,990	6,303	10,293	14.00
15.00	01500	PHARMACY	0	4,337	14,255	18,592	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,877	19	4,896	16.00
17.00	01700	SOCIAL SERVICE	0	416	0	416	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	24,044	7,522	31,566	30.00
46.00	04600	OTHER LONG TERM CARE	0	27,944	1,762	29,706	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	16,480	2,930	19,410	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,470	2,470	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,726	58,378	73,104	54.00
60.00	06000	LABORATORY	0	9,204	1,570	10,774	60.00
65.00	06500	RESPIRATORY THERAPY	0	491	2,865	3,356	65.00
66.00	06600	PHYSICAL THERAPY	0	12,619	5,917	18,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	2,012	10,289	12,301	68.01
69.00	06900	ELECTROCARDIOLOGY	0	238	1,785	2,023	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	17,734	48	17,782	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	13,174	5,439	18,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	245,914	126,130	372,044	658
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	11,410	0	11,410	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	257,324	126,130	383,454	659

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description			INFORMATION SYSTEMS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	6.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS	7,491					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,339	25,363				5.02
6.00	00600	MAINTENANCE & REPAIRS	116	1,378	43,867			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	286	703	3,983		8.00
9.00	00900	HOUSEKEEPING	116	604	460	0	3,159	9.00
10.00	01000	DIETARY	174	924	2,810	0	208	10.00
11.00	01100	CAFETERIA	0	40	853	0	63	11.00
13.00	01300	NURSING ADMINISTRATION	58	21	611	0	45	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	116	242	937	0	69	14.00
15.00	01500	PHARMACY	232	521	1,018	0	75	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	348	608	1,145	0	85	16.00
17.00	01700	SOCIAL SERVICE	0	17	98	0	7	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	148	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	697	2,313	5,645	525	418	30.00
46.00	04600	OTHER LONG TERM CARE	232	1,670	6,559	2,854	485	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	290	686	3,869	76	286	50.00
53.00	05300	ANESTHESIOLOGY	0	25	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	697	1,739	3,457	94	256	54.00
60.00	06000	LABORATORY	290	2,432	2,161	0	160	60.00
65.00	06500	RESPIRATORY THERAPY	0	79	115	0	9	65.00
66.00	06600	PHYSICAL THERAPY	929	2,550	2,963	217	219	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	58	219	472	0	35	68.01
69.00	06900	ELECTROCARDIOLOGY	0	24	56	0	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,488	0	0	0	73.00
76.00	03480	ONCOLOGY	58	9	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,103	3,706	4,163	6	308	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	348	3,392	3,093	192	229	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,201	25,240	41,188	3,964	2,961	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	290	105	2,679	19	198	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,491	25,363	43,867	3,983	3,159	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	16,694					10.00
11.00	01100	CAFETERIA	0	4,591				11.00
13.00	01300	NURSING ADMINISTRATION	0	2	3,339			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	87	0	11,750		14.00
15.00	01500	PHARMACY	0	58	0	5	20,516	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	217	0	9	0	16.00
17.00	01700	SOCIAL SERVICE	0	5	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,431	634	985	2,196	25	30.00
46.00	04600	OTHER LONG TERM CARE	13,176	881	1,317	1,438	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	119	182	1,227	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	315	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	274	0	250	11	54.00
60.00	06000	LABORATORY	0	396	0	200	7	60.00
65.00	06500	RESPIRATORY THERAPY	0	1	1	207	0	65.00
66.00	06600	PHYSICAL THERAPY	0	668	0	115	40	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	54	80	70	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	7	12	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,437	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,064	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	20,168	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	690	0	271	11	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	486	742	1,943	254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,607	4,579	3,319	11,747	20,516	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	12	20	3	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	87	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,694	4,591	3,339	11,750	20,516	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/24/2019 8:12 am

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	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,328					16.00
17.00	01700	SOCIAL SERVICE	0	544				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	148			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	392	490		49,390	0	30.00
46.00	04600	OTHER LONG TERM CARE	420	54		58,851	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	489	0		26,649	0	50.00
53.00	05300	ANESTHESIOLOGY	23	0		2,833	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,889	0		81,806	0	54.00
60.00	06000	LABORATORY	1,491	0		17,954	0	60.00
65.00	06500	RESPIRATORY THERAPY	32	0		3,800	0	65.00
66.00	06600	PHYSICAL THERAPY	953	0		27,278	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
68.01	06801	CARDIAC REHAB	60	0		13,355	0	68.01
69.00	06900	ELECTROCARDIOLOGY	74	0		2,201	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29	0		2,563	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9	0		1,095	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	541	0		22,197	0	73.00
76.00	03480	ONCOLOGY	13	0		80	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	403	0		28,559	0	88.00
90.00	09000	CLINIC	0	0		0	0	90.00
91.00	09100	EMERGENCY	510	0		29,853	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0		0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,328	544	0	368,464	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		18	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0		14,737	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		87	0	190.02
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
200.00		Cross Foot Adjustments			148	148	0	200.00
201.00		Negative Cost Centers	0	0		0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	7,328	544	148	383,454	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet B
Part II
Date/Time Prepared:
9/24/2019 8:12 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	00550	INFORMATION SYSTEMS	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	5.02
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
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
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
68.01	06801	CARDIAC REHAB	68.01
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03480	ONCOLOGY	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	98.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	OUTPATIENT CLINIC	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	190.02
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
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: 14-1308

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION SYSTEMS (# OF COMPUTERS)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5.01	5A.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	51,917				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		127,418			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	133	0	5,992,658		4.00
5.01	00550	INFORMATION SYSTEMS	928	2,902	167,255	129	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	4,652	923	480,315	23	-1,648,336
6.00	00600	MAINTENANCE & REPAIRS	8,505	209	102,598	2	0
8.00	00800	LAUNDRY & LINEN SERVICE	604	0	0	0	0
9.00	00900	HOUSEKEEPING	395	0	186,739	2	0
10.00	01000	DIETARY	2,415	590	216,416	3	0
11.00	01100	CAFETERIA	733	0	15,119	0	0
13.00	01300	NURSING ADMINISTRATION	525	0	1,994	1	0
14.00	01400	CENTRAL SERVICES & SUPPLY	805	6,367	58,186	2	0
15.00	01500	PHARMACY	875	14,401	131,956	4	0
16.00	01600	MEDICAL RECORDS & LIBRARY	984	19	178,385	6	0
17.00	01700	SOCIAL SERVICE	84	0	5,617	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,851	7,599	660,271	12	0
46.00	04600	OTHER LONG TERM CARE	5,638	1,780	532,294	4	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,325	2,960	133,931	5	0
53.00	05300	ANESTHESIOLOGY	0	2,495	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,971	58,976	315,525	12	0
60.00	06000	LABORATORY	1,857	1,586	389,660	5	0
65.00	06500	RESPIRATORY THERAPY	99	2,894	1,009	0	0
66.00	06600	PHYSICAL THERAPY	2,546	5,977	802,443	16	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
68.01	06801	CARDIAC REHAB	406	10,394	58,797	1	0
69.00	06900	ELECTROCARDIOLOGY	48	1,803	6,778	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	03480	ONCOLOGY	0	0	0	1	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,578	48	1,075,003	19	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,658	5,495	459,558	6	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,615	127,418	5,979,849	124	-1,648,336
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
190.01	19001	OUTPATIENT CLINIC	2,302	0	12,809	5	0
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
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)	257,324	126,130	1,842,158	506,320	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.956450	0.989892	0.307402	3,924.961240	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			659	7,491	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000110	58.069767	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: 14-1308

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5.02	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	INFORMATION SYSTEMS					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	11,624,506				5.02
6.00	00600	MAINTENANCE & REPAIRS	631,468	37,699			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	131,143	604	36,860		8.00
9.00	00900	HOUSEKEEPING	276,598	395	0	36,700	9.00
10.00	01000	DIETARY	423,294	2,415	0	2,415	33,469 10.00
11.00	01100	CAFETERIA	18,273	733	0	733	0 11.00
13.00	01300	NURSING ADMINISTRATION	9,476	525	0	525	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	110,863	805	0	805	0 14.00
15.00	01500	PHARMACY	238,990	875	0	875	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	278,528	984	0	984	0 16.00
17.00	01700	SOCIAL SERVICE	7,760	84	0	84	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	67,800	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,060,060	4,851	4,858	4,851	6,878 30.00
46.00	04600	OTHER LONG TERM CARE	765,360	5,638	26,409	5,638	26,416 46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	314,272	3,325	703	3,325	0 50.00
53.00	05300	ANESTHESIOLOGY	11,519	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	796,959	2,971	874	2,971	0 54.00
60.00	06000	LABORATORY	1,114,537	1,857	0	1,857	0 60.00
65.00	06500	RESPIRATORY THERAPY	36,113	99	0	99	0 65.00
66.00	06600	PHYSICAL THERAPY	1,168,619	2,546	2,007	2,546	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
68.01	06801	CARDIAC REHAB	100,185	406	0	406	0 68.01
69.00	06900	ELECTROCARDIOLOGY	11,063	48	0	48	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,682	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,132	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	681,849	0	0	0	0 73.00
76.00	03480	ONCOLOGY	3,925	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,700,126	3,578	58	3,578	0 88.00
90.00	09000	CLINIC	0	0	0	0	0 90.00
91.00	09100	EMERGENCY	1,554,676	2,658	1,774	2,658	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,568,270	35,397	36,683	34,398	33,294 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,265	0	0	0	0 190.00
190.01	19001	OUTPATIENT CLINIC	47,971	2,302	177	2,302	0 190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	175 190.02
191.00	19100	RESEARCH	0	0	0	0	0 191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,648,336	721,009	161,291	323,374	550,783 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.141798	19.125414	4.375773	8.811281	16.456512 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,363	43,867	3,983	3,159	16,694 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002182	1.163612	0.108058	0.086076	0.498790 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: 14-1308

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description			CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
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	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	8,478					11.00
13.00	01300	NURSING ADMINISTRATION	3	77,932				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	160	0	111,942			14.00
15.00	01500	PHARMACY	108	0	45	693,603		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	400	0	90	0	20,505,731	16.00
17.00	01700	SOCIAL SERVICE	10	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,171	22,994	20,926	859	1,096,891	30.00
46.00	04600	OTHER LONG TERM CARE	1,627	30,756	13,702	0	1,177,856	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	219	4,249	11,693	3	1,369,403	50.00
53.00	05300	ANESTHESIOLOGY	0	0	3,004	2	63,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	506	0	2,381	361	5,271,831	54.00
60.00	06000	LABORATORY	732	0	1,905	222	4,176,205	60.00
65.00	06500	RESPIRATORY THERAPY	1	28	1,968	0	88,389	65.00
66.00	06600	PHYSICAL THERAPY	1,234	0	1,093	1,356	2,669,074	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	99	1,856	664	0	168,786	68.01
69.00	06900	ELECTROCARDIOLOGY	13	271	0	0	208,003	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	23,212	0	80,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	10,132	0	25,364	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	681,849	1,515,997	73.00
76.00	03480	ONCOLOGY	0	0	4	0	36,064	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,275	0	2,586	369	1,128,959	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	898	17,311	18,512	8,582	1,429,669	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,456	77,465	111,917	693,603	20,505,731	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	22	467	25	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	41,342	25,502	149,852	297,910	347,583	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.876386	0.327234	1.338658	0.429511	0.016951	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,591	3,339	11,750	20,516	7,328	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.541519	0.042845	0.104965	0.029579	0.000357	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: 14-1308

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

Worksheet B-1

Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		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	00550	INFORMATION SYSTEMS		5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL		5.02
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
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	90	30.00
46.00	04600	OTHER LONG TERM CARE	10	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	100	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
68.01	06801	CARDIAC REHAB	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03480	ONCOLOGY	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	93.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	98.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	190.02
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,256	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	112.560000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	544	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.440000	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: 14-1308

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

Worksheet B-2

Date/Time Prepared:
9/24/2019 8:12 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0
7.00		ADULTS AND PEDIATRICS		1	30.00	-45,747
8.00		OTHER OUTPATIENT SERVICES		1	93.00	45,747

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 8:12 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	1,504,933		1,504,933	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,639,099		1,639,099	0	0	46.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	496,126		496,126	0	0	50.00
53.00	05300	ANESTHESIOLOGY	95,659		95,659	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,091,953		1,091,953	0	0	54.00
60.00	06000	LABORATORY	1,401,461		1,401,461	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	48,145	0	48,145	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,467,541	0	1,467,541	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	130,573	0	130,573	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	17,651		17,651	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,451		83,451	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,562		25,562	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,097,095		1,097,095	0	0	73.00
76.00	03480	ONCOLOGY	5,098		5,098	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,070,390		2,070,390	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,919,889		1,919,889	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	34,784		34,784	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	45,747		45,747	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	13,175,157	0	13,175,157	0	0	200.00
201.00		Less Observation Beds	34,784		34,784		0	201.00
202.00		Total (see instructions)	13,140,373	0	13,140,373	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 8:12 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	591,261		591,261		30.00
46.00	04600	OTHER LONG TERM CARE	1,177,856		1,177,856		46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,369,403	1,369,403	0.362294	50.00
53.00	05300	ANESTHESIOLOGY	0	63,187	63,187	1.513903	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,637	5,215,194	5,271,831	0.207130	54.00
60.00	06000	LABORATORY	160,248	4,015,957	4,176,205	0.335582	60.00
65.00	06500	RESPIRATORY THERAPY	47,903	40,486	88,389	0.544694	65.00
66.00	06600	PHYSICAL THERAPY	489,490	2,179,584	2,669,074	0.549832	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	168,786	168,786	0.773601	68.01
69.00	06900	ELECTROCARDIOLOGY	1,900	206,103	208,003	0.084859	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,997	65,056	80,053	1.042447	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,364	25,364	1.007806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	273,960	1,242,037	1,515,997	0.723679	73.00
76.00	03480	ONCOLOGY	0	36,064	36,064	0.141360	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,128,959	1,128,959		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	1,429,669	1,429,669	1.342891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	31,485	31,485	1.104780	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	14,478	459,667	474,145	0.096483	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
200.00		Subtotal (see instructions)	2,828,730	17,677,001	20,505,731		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,828,730	17,677,001	20,505,731		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 8:12 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
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

Worksheet C
Part I
Date/Time Prepared:

MCRIF32 - 15.8.166.0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 8:12 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	591,261		591,261		30.00
46.00	04600	OTHER LONG TERM CARE	1,177,856		1,177,856		46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,369,403	1,369,403	0.362294	50.00
53.00	05300	ANESTHESIOLOGY	0	63,187	63,187	1.513903	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	56,637	5,215,194	5,271,831	0.207130	54.00
60.00	06000	LABORATORY	160,248	4,015,957	4,176,205	0.335582	60.00
65.00	06500	RESPIRATORY THERAPY	47,903	40,486	88,389	0.544694	65.00
66.00	06600	PHYSICAL THERAPY	489,490	2,179,584	2,669,074	0.549832	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	168,786	168,786	0.773601	68.01
69.00	06900	ELECTROCARDIOLOGY	1,900	206,103	208,003	0.084859	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,997	65,056	80,053	1.042447	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,364	25,364	1.007806	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	273,960	1,242,037	1,515,997	0.723679	73.00
76.00	03480	ONCOLOGY	0	36,064	36,064	0.141360	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,128,959	1,128,959	1.833893	88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	1,429,669	1,429,669	1.342891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	31,485	31,485	1.104780	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	14,478	459,667	474,145	0.096483	93.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
200.00		Subtotal (see instructions)	2,828,730	17,677,001	20,505,731		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	2,828,730	17,677,001	20,505,731		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet C
Part I
Date/Time Prepared:
9/24/2019 8:12 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
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
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
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03480	ONCOLOGY	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
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: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part II
Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital 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	26,649	1,369,403	0.019460	0	0	50.00
53.00	05300 ANESTHESIOLOGY	2,833	63,187	0.044835	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	81,806	5,271,831	0.015518	32,244	500	54.00
60.00	06000 LABORATORY	17,954	4,176,205	0.004299	45,505	196	60.00
65.00	06500 RESPIRATORY THERAPY	3,800	88,389	0.042992	7,211	310	65.00
66.00	06600 PHYSICAL THERAPY	27,278	2,669,074	0.010220	17,783	182	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	13,355	168,786	0.079124	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	2,201	208,003	0.010582	380	4	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,563	80,053	0.032016	2,496	80	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,095	25,364	0.043171	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,197	1,515,997	0.014642	33,240	487	73.00
76.00	03480 ONCOLOGY	80	36,064	0.002218	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	28,559	1,128,959	0.025297	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	29,853	1,429,669	0.020881	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,142	31,485	0.036271	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	474,145	0.000000	10,017	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0.000000	0	0	95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50 through 199)	261,365	18,736,614		148,876	1,759	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1308		Period: From 05/01/2018 To 04/30/2019		Worksheet D Part IV Date/Time Prepared: 9/24/2019 8:12 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	77,414	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50 through 199)	77,414	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/24/2019 8:12 am

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	1,369,403	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	77,414	0	63,187	1.225157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,271,831	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	4,176,205	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	88,389	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,669,074	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	0	0	168,786	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	208,003	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	80,053	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,364	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,515,997	0.000000	73.00
76.00	03480	ONCOLOGY	0	0	0	36,064	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,128,959	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	1,429,669	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	31,485	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	474,145	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0.000000	98.00
200.00		Total (lines 50 through 199)	0	77,414	0	18,736,614		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part IV
Date/Time Prepared:
9/24/2019 8:12 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
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	32,244	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	45,505	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	7,211	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	17,783	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	380	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,496	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	33,240	0	0	0	73.00
76.00	03480	ONCOLOGY	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	10,017	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Total (lines 50 through 199)		148,876	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
9/24/2019 8:12 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	0.362294	0	614,023	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	1.513903	0	29,021	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.207130	0	2,065,434	0	0	54.00	
60.00	06000	LABORATORY	0.335582	0	1,671,794	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.544694	0	16,232	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.549832	0	943,105	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
68.01	06801	CARDIAC REHAB	0.773601	0	114,789	0	0	68.01	
69.00	06900	ELECTROCARDIOLOGY	0.084859	0	105,685	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.042447	0	31,582	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.007806	0	16,412	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.723679	0	642,751	11,106	0	73.00	
76.00	03480	ONCOLOGY	0.141360	0	24,406	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	1.342891	0	457,845	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.104780	0	14,845	0	0	92.00	
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.096483	0	215,863	6,059	0	93.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00	
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00	
200.00		Subtotal (see instructions)		0	6,963,787	17,165	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	6,963,787	17,165	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet D
Part V
Date/Time Prepared:
9/24/2019 8:12 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	222,457	0		50.00
53.00	05300	ANESTHESIOLOGY	43,935	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	427,813	0		54.00
60.00	06000	LABORATORY	561,024	0		60.00
65.00	06500	RESPIRATORY THERAPY	8,841	0		65.00
66.00	06600	PHYSICAL THERAPY	518,549	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	88,801	0		68.01
69.00	06900	ELECTROCARDIOLOGY	8,968	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,923	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,540	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	465,145	8,037		73.00
76.00	03480	ONCOLOGY	3,450	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	614,836	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,400	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	20,827	585		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	3,050,509	8,622		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,050,509	8,622		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308

Period:

Worksheet D

Component CCN: 14-Z308

From 05/01/2018
To 04/30/2019Part V
Date/Time Prepared:
9/24/2019 8:12 am

			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
					3.00	4.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.362294	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.513903	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.207130	0	0	0	0	54.00
60.00	06000	LABORATORY	0.335582	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.544694	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.549832	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0.773601	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.084859	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.042447	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.007806	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.723679	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0.141360	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.342891	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.104780	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.096483	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1308

Period:

Worksheet D

Component CCN: 14-Z308

From 05/01/2018
To 04/30/2019Part V
Date/Time Prepared:
9/24/2019 8:12 am

				Title XVIII	Swing Beds - SNF	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03480	ONCOLOGY	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
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: 14-1308

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

Worksheet D-1

Date/Time Prepared:
9/24/2019 8:12 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)	1,862	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	238	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)	201	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	899	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)	411	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	215	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)	99	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	144	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)	824	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)	387	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	156.49	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	161.18	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,504,933	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)	33,645	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)	15,957	25.00
26.00	Total swing-bed cost (see instructions)	1,281,185	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	223,748	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)	223,748	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)	940.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	135,380	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)	135,380	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1308

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

Worksheet D-1

Date/Time Prepared:
9/24/2019 8:12 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)					63,311	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					198,691	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)					774,675	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					363,834	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,138,509	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)					37	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					940.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					34,784	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1308

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

Worksheet D-1

Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	49,390	1,504,933	0.032819	34,784	1,142	90.00
91.00	Nursing School cost	0	1,504,933	0.000000	34,784	0	91.00
92.00	Allied health cost	0	1,504,933	0.000000	34,784	0	92.00
93.00	All other Medical Education	0	1,504,933	0.000000	34,784	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1308	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 9/24/2019 8:12 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		123,900		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.362294	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.513903	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207130	32,244	6,679	54.00
60.00	06000 LABORATORY	0.335582	45,505	15,271	60.00
65.00	06500 RESPIRATORY THERAPY	0.544694	7,211	3,928	65.00
66.00	06600 PHYSICAL THERAPY	0.549832	17,783	9,778	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	0.773601	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.084859	380	32	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.042447	2,496	2,602	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.007806	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.723679	33,240	24,055	73.00
76.00	03480 ONCOLOGY	0.141360	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.342891	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.104780	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.096483	10,017	966	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		148,876	63,311	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)		148,876		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1308 Component CCN: 14-Z308	Period: From 05/01/2018 To 04/30/2019	Worksheet D-3 Date/Time Prepared: 9/24/2019 8:12 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	0.362294	0	0	50.00
53.00	05300 ANESTHESIOLOGY	1.513903	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.207130	13,824	2,863	54.00
60.00	06000 LABORATORY	0.335582	82,267	27,607	60.00
65.00	06500 RESPIRATORY THERAPY	0.544694	26,724	14,556	65.00
66.00	06600 PHYSICAL THERAPY	0.549832	391,592	215,310	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801 CARDIAC REHAB	0.773601	0	0	68.01
69.00	06900 ELECTROCARDIOLOGY	0.084859	1,140	97	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.042447	9,005	9,387	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.007806	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.723679	170,290	123,235	73.00
76.00	03480 ONCOLOGY	0.141360	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	1.342891	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.104780	0	0	92.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.096483	377	36	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		695,219	393,091	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)		695,219		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1308	Period: From 05/01/2018 To 04/30/2019	Worksheet E Part B Date/Time Prepared: 9/24/2019 8:12 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,059,131	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,059,131	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		3,089,722	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)		19,936	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,054,564	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,015,222	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,015,222	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,015,222	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)		104,248	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		67,761	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		104,248	36.00
37.00	Subtotal (see instructions)		2,082,983	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,082,983	40.00
40.01	Sequestration adjustment (see instructions)		41,660	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,409,594	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-368,271	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: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet E-1
Part I
Date/Time Prepared:
9/24/2019 8:12 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		126,762		2,367,638	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	04/30/2019	41,956	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		41,956	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)		126,762		2,409,594	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		31,744		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		368,271	6.02	
7.00	Total Medicare program liability (see instructions)		158,506		2,041,323	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: 14-1308

Period:

Worksheet E-1

Component CCN: 14-Z308

From 05/01/2018
To 04/30/2019Part I
Date/Time Prepared:
9/24/2019 8:12 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,394,493		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,394,493		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		72,557		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,467,050		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: 14-1308	Period: From 05/01/2018 To 04/30/2019	Worksheet E-1 Part II Date/Time Prepared: 9/24/2019 8:12 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: 14-1308

Period:

Worksheet E-2

Component CCN: 14-Z308

From 05/01/2018

To 04/30/2019

Date/Time Prepared:

9/24/2019 8:12 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1,149,894	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)		397,022	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		1,211	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)		1,546,916	0	8.00
9.00	Primary payer payments (see instructions)		20,948	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,525,968	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)		1,525,968	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		28,978	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)		1,496,990	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)		1,496,990	0	19.00
19.01	Sequestration adjustment (see instructions)		29,940	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,394,493	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)		72,557	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1308	Period: From 05/01/2018 To 04/30/2019	Worksheet E-3 Part V Date/Time Prepared: 9/24/2019 8:12 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		198,691	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)		198,691	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		200,678	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)		200,678	19.00
20.00	Deductibles (exclude professional component)		46,419	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		154,259	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		154,259	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		11,511	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		7,482	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		11,511	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		161,741	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)		161,741	30.00
30.01	Sequestration adjustment (see instructions)		3,235	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		126,762	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)		31,744	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: 14-1308

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

Worksheet G

Date/Time Prepared:

9/24/2019 8:12 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	443,870	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	1,965,435	0	0	0	4.00
5.00	Other receivable	65,444	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-325,000	0	0	0	6.00
7.00	Inventory	369,801	0	0	0	7.00
8.00	Prepaid expenses	92,074	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	2,611,624	0	0	0	11.00
FIXED ASSETS						
12.00	Land	62,855	0	0	0	12.00
13.00	Land improvements	419,030	0	0	0	13.00
14.00	Accumulated depreciation	-399,300	0	0	0	14.00
15.00	Buildings	9,515,946	0	0	0	15.00
16.00	Accumulated depreciation	-8,022,723	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	5,317,465	0	0	0	23.00
24.00	Accumulated depreciation	-4,909,417	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	927,041	0	0	0	27.00
28.00	Accumulated depreciation	-924,169	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)	1,986,728	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	669,973	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	669,973	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	5,268,325	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	266,831	0	0	0	37.00
38.00	Salaries, wages, and fees payable	647,640	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	250,248	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	745,809	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,910,528	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	794,955	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)	794,955	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,705,483	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,562,842				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)	2,562,842	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	5,268,325	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1308

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

Worksheet G-1

Date/Time Prepared:
9/24/2019 8:12 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		2,663,137		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-100,295				2.00
3.00	Total (sum of line 1 and line 2)		2,562,842		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		2,562,842		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,562,842		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1308

Period:
From 05/01/2018
To 04/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
9/24/2019 8:12 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	194,865		194,865	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	396,396		396,396	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	1,177,856		1,177,856	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,769,117		1,769,117	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)	1,769,117		1,769,117	17.00
18.00	Ancillary services	1,045,135	17,126,027	18,171,162	18.00
19.00	Outpatient services	0	474,145	474,145	19.00
20.00	RURAL HEALTH CLINIC	0	1,835,572	1,835,572	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	CHARITY CARE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	2,814,252	19,435,744	22,249,996	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,672,043		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,672,043		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1308

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

Worksheet G-3

Date/Time Prepared:
9/24/2019 8:12 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	22,249,996	1.00
2.00	Less contractual allowances and discounts on patients' accounts	9,454,007	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,795,989	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,672,043	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-876,054	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	25,085	6.00
7.00	Income from investments	19,905	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	3,691	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	19,493	22.00
23.00	Governmental appropriations	397,912	23.00
24.00	GRANT INCOME	21,756	24.00
24.01	MEDICARE AND MEDICAID INCENTIVE REV	8,500	24.01
24.02	GAIN ON DISPOSAL OF FIXED ASSETS	245	24.02
24.03	OTHER MISCELLANEOUS INCOME	25,442	24.03
24.04	340B	253,730	24.04
25.00	Total other income (sum of lines 6-24)	775,759	25.00
26.00	Total (line 5 plus line 25)	-100,295	26.00
27.00	OTHER EXPENSES	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)	-100,295	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308

Period:

Worksheet M-1

Component CCN: 14-3472

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

Date/Time Prepared:

9/24/2019 8:12 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	507,585	0	507,585	0	507,585
2.00	Physician Assistant	224,319	0	224,319	0	224,319
3.00	Nurse Practitioner	0	0	0	0	0
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	343,099	0	343,099	0	343,099
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0
10.00	Subtotal (sum of lines 1 through 9)	1,075,003	0	1,075,003	0	1,075,003
11.00	Physician Services Under Agreement	0	271,902	271,902	0	271,902
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	61,548	61,548	0	61,548
14.00	Subtotal (sum of lines 11 through 13)	0	333,450	333,450	0	333,450
15.00	Medical Supplies	0	6,727	6,727	0	6,727
16.00	Transportation (Health Care Staff)	0	181	181	0	181
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	39,997	39,997	-39,997	0
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	46,905	46,905	-39,997	6,908
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,075,003	380,355	1,455,358	-39,997	1,415,361
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	920	920	0	920
30.00	Administrative Costs	0	8,754	8,754	0	8,754
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	9,674	9,674	0	9,674
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,075,003	390,029	1,465,032	-39,997	1,425,035

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1308

Period:

Worksheet M-1

Component CCN: 14-3472

From 05/01/2018
To 04/30/2019Date/Time Prepared:
9/24/2019 8:12 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	-27,079	480,506	1.00
2.00	Physician Assistant	0	224,319	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	343,099	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	-27,079	1,047,924	10.00
11.00	Physician Services Under Agreement	-120,522	151,380	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	-122	61,426	13.00
14.00	Subtotal (sum of lines 11 through 13)	-120,644	212,806	14.00
15.00	Medical Supplies	0	6,727	15.00
16.00	Transportation (Health Care Staff)	0	181	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs			20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,908	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-147,723	1,267,638	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs			27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	920	29.00
30.00	Administrative Costs	0	8,754	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	9,674	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-147,723	1,277,312	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1308

Period:

Worksheet M-2

Component CCN: 14-3472

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

Date/Time Prepared:

9/24/2019 8:12 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.89	5,478	4,200	7,938		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.55	4,299	2,100	3,255		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.44	9,777		11,193	11,193	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.44	9,777			11,193	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)					1,267,638	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,267,638	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					9,674	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					793,078	15.00
16.00	Total overhead (sum of lines 14 and 15)					802,752	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					802,752	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					802,752	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,070,390	20.00

Health Financial Systems		WASHINGTON COUNTY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1308	Period: From 05/01/2018 To 04/30/2019	Worksheet M-3	
		Component CCN: 14-3472		Date/Time Prepared: 9/24/2019 8:12 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)			2,070,390	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			33,194	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,037,196	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11,193	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)			11,193	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			182.01	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)		182.01	182.01	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,986	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	543,482	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	543,482	16.00
16.01	Total program charges (see instructions)(from contractor's records)			393,125	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			390,545	16.04
16.05	Total program cost (see instructions)		0	390,545	16.05
17.00	Primary payer amounts			34	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			55,301	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			67,565	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			390,511	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			263	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			390,774	22.00
23.00	Allowable bad debts (see instructions)			7,313	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			4,753	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			7,313	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)			395,527	26.00
26.01	Sequestration adjustment (see instructions)			7,911	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			369,684	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)			17,932	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: 14-1308 Component CCN: 14-3472	Period: From 05/01/2018 To 04/30/2019	Worksheet M-4 Date/Time Prepared: 9/24/2019 8:12 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)		1,047,924	1,047,924	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000394	0.000835	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		413	875	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		15,542	3,494	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		15,955	4,369	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,267,638	1,267,638	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		802,752	802,752	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.012586	0.003447	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		10,103	2,767	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		26,058	7,136	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		99	210	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		263.21	33.98	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		1	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		263	0	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)			33,194	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)			263	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1308 Component CCN: 14-3472	Period: From 05/01/2018 To 04/30/2019	Worksheet M-5 Date/Time Prepared: 9/24/2019 8:12 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		369,684	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01			0		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		369,684		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		17,932		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		387,616		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00