

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet S Parts I-III Date/Time Prepared: 11/18/2019 4:25 pm
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/18/2019	Time: 4:25 pm
	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 FRANKLIN HOSPITAL (14-1321) for the cost reporting period beginning 07/01/2018 and ending 06/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) JAMES JOHNSON

Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	114,191	240,761	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	59,208	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		34,349		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-28,361		0	10.01
200.00	Total	0	173,399	246,749	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: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 4:25 pm	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 201 BAILEY LANE			PO Box:				1.00		
2.00	City: BENTON			State: IL		Zip Code: 62812		County: FRANKLIN		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		FRANKLIN HOSPITAL	141321	99914	1	08/01/2002	N	O	N
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		FRANKLIN HOSPITAL SWING BED	14Z321	99914		08/01/2002	N	O	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		FRANKLIN RHC	143469	99914		07/06/2005	N	O	N
15.01	Hospital-Based Health Clinic - RHC II		WEST FRANKFORT RHC	148510	99914		04/23/2010	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2018	06/30/2019		20.00
21.00	Type of Control (see instructions)						9			21.00
							1.00	2.00	3.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

	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: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 4:25 pm	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
			1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)							61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)							61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)							61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).							61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)							61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)							61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
			1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20	
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						N	63.00
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 4:25 pm	
				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
			Physical	Occupational	
			1.00	2.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		Y	Y	109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 4:25 pm	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	129,715	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	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: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet S-2 Part I Date/Time Prepared: 11/18/2019 4:25 pm	
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)					10/01/2018	12/31/2018		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/18/2019 4:25 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N			14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N			15.00
			Part A		Part B
			Y/N	Date	Y/N
			1.00	2.00	3.00
			4.00		
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/09/2019	Y	10/09/2019
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet S-2
Part II
Date/Time Prepared:
11/18/2019 4:25 pm

		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		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN		41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet S-2 Part II Date/Time Prepared: 11/18/2019 4:25 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	12,624.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	12,624.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	12,624.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

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)	385	38	526			1.00
2.00	HMO and other (see instructions)	3	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	283	0	303			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	668	38	843			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)	668	38	843	0.00	123.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	6,904	1,906	18,022	0.00	18.64	26.00
26.01	RURAL HEALTH CLINIC II	508	23	1,072	0.00	1.52	26.01
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	143.58	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: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet S-3
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

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	127	19	185	1.00
2.00 HMO and other (see instructions)			1	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	127	19	185	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.01 RURAL HEALTH CLINIC II	0.00					26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1321 Component CCN: 14-3469		Period: From 07/01/2018 To 06/30/2019		Worksheet S-8 Date/Time Prepared: 11/18/2019 4:25 pm	
		RHC I		Cost			
		1.00					
Clinic Address and Identification							
1.00	Street		201 BAILEY LANE				1.00
		City	State	ZIP Code			
		1.00	2.00	3.00			
2.00	City, State, ZIP Code, County		BENTON IL 62812				2.00
		1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0		3.00
		Grant Award		Date			
		1.00		2.00			
Source of Federal Funds							
4.00	Community Health Center (Section 330(d), PHS Act)						4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
		1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0		10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
Facility hours of operations (1)							
11.00	CLINIC	12:00	18:00	09:00	20:00	09:00	11.00
		1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?		N				12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N		0		13.00
		Provider name		CCN number			
		1.00		2.00			
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
		County					
		4.00					
2.00	City, State, ZIP Code, County		FRANKLIN				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)							
11.00	CLINIC	20:00	09:00	20:00	09:00	20:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1321

Period:

Worksheet S-8

Component CCN: 14-3469

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

Date/Time Prepared:

11/18/2019 4:25 pm

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	09:00	20:00	09:00	19:00		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

 Provider CCN: 14-1321
 Component CCN: 14-8510

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

Worksheet S-8

 Date/Time Prepared:
 11/18/2019 4:25 pm

				RHC II		Cost	
				1.00			
Clinic Address and Identification							
1.00	Street			309 WEST ST. LOUIS STREET		1.00	
			City	State	ZIP Code		
			1.00	2.00	3.00		
2.00	City, State, ZIP Code, County			WEST FRANKFORT IL 62896		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	
				from	to	from	to
				1.00	2.00	3.00	4.00
				Tuesday		from	
				1.00		2.00	
11.00	Facility hours of operations (1)			CLINIC		11.00	
				09:00		17:00	
				09:00		11.00	
				1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00	RHC/FQHC name, CCN number					14.00	
				Y/N	V	XVIII	XIX
				1.00	2.00	3.00	4.00
				Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15.00	
				County		4.00	
2.00	City, State, ZIP Code, County			FRANKLIN		2.00	
				Tuesday	Wednesday	Thursday	
				to	from	to	from
				6.00	7.00	8.00	9.00
				10.00			
Facility hours of operations (1)							
11.00	CLINIC			17:00	09:00	17:00	09:00
				17:00		11.00	

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1321

Period:

Worksheet S-8

Component CCN: 14-8510

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/18/2019 4:25 pm

RHC II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	CLINIC	09:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-1321

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

Worksheet S-10

Date/Time Prepared:
11/18/2019 4:25 pm

				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)			0.433486	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			1,454,881	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			2,089,371	5.00
6.00	Medicaid charges			5,116,273	6.00
7.00	Medicaid cost (line 1 times line 6)			2,217,833	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	130,827	179,737	310,564	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	56,712	179,737	236,449	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	56,712	179,737	236,449	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,513,371	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			361,932	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			556,818	27.01
28.00	Non-Medicare bad debt expense (see instructions)			1,956,553	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,043,024	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,279,473	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,279,473	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet A Date/Time Prepared: 11/18/2019 4:25 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT		134,106	134,106	139,526	273,632	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		543,504	543,504	91,445	634,949	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	96,038	2,058,274	2,154,312	0	2,154,312	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	1,428,174	1,172,141	2,600,315	151,818	2,752,133	5.00	
6.00	00600	MAINTENANCE & REPAIRS	233,952	112,331	346,283	-371	345,912	6.00	
7.00	00700	OPERATION OF PLANT	0	392,081	392,081	-30,968	361,113	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,943	74,943	0	74,943	8.00	
9.00	00900	HOUSEKEEPING	223,617	44,092	267,709	0	267,709	9.00	
10.00	01000	DIETARY	215,822	174,837	390,659	-327,516	63,143	10.00	
11.00	01100	CAFETERIA	0	0	0	327,516	327,516	11.00	
13.00	01300	NURSING ADMINISTRATION	443,984	37,055	481,039	0	481,039	13.00	
14.00	01400	CENTRAL SERVICE & SUPPLY	89,883	9,844	99,727	0	99,727	14.00	
15.00	01500	PHARMACY	213,344	1,393,737	1,607,081	-1,038,266	568,815	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	198,715	74,480	273,195	0	273,195	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	776,319	489,269	1,265,588	-316	1,265,272	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	163,506	211,179	374,685	-21	374,664	50.00	
53.00	05300	ANESTHESIOLOGY	0	41,096	41,096	-287	40,809	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	428,179	139,391	567,570	-12,298	555,272	54.00	
57.00	05700	CT SCAN	0	89,464	89,464	12,298	101,762	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	76,365	76,365	0	76,365	58.00	
60.00	06000	LABORATORY	436,084	832,919	1,269,003	-4,040	1,264,963	60.00	
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	29,479	29,479	4,040	33,519	63.00	
65.00	06500	RESPIRATORY THERAPY	250,616	72,551	323,167	-4,893	318,274	65.00	
66.00	06600	PHYSICAL THERAPY	0	196,251	196,251	0	196,251	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	40,081	40,081	0	40,081	67.00	
68.00	06800	SPEECH PATHOLOGY	0	10,881	10,881	0	10,881	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	59,164	59,164	5,201	64,365	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,038,266	1,038,266	73.00	
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	208,824	201,988	410,812	0	410,812	76.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	1,952,637	439,350	2,391,987	-36,960	2,355,027	88.00	
88.01	08801	RURAL HEALTH CLINIC II	144,895	67,688	212,583	-9,106	203,477	88.01	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	628,028	1,837,428	2,465,456	0	2,465,456	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE		305,068	305,068	-305,068	0	113.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,132,617	11,361,037	19,493,654	0	19,493,654	118.00	
NONREIMBURSABLE COST CENTERS									
192.00	19200	PHYSICIANS' PRIVATE OFFICES	309,502	35,400	344,902	0	344,902	192.00	
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00	
200.00		TOTAL (SUM OF LINES 118 through 199)	8,442,119	11,396,437	19,838,556	0	19,838,556	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1321

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

Worksheet A

Date/Time Prepared:
11/18/2019 4:25 pm

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	-369	273,263	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-183,775	451,174	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10,794	2,143,518	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-60,147	2,691,986	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	345,912	6.00
7.00	00700	OPERATION OF PLANT	-100,373	260,740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,943	8.00
9.00	00900	HOUSEKEEPING	0	267,709	9.00
10.00	01000	DIETARY	0	63,143	10.00
11.00	01100	CAFETERIA	-107,244	220,272	11.00
13.00	01300	NURSING ADMINISTRATION	0	481,039	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	99,727	14.00
15.00	01500	PHARMACY	-267,617	301,198	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,205	267,990	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-271,809	993,463	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-47,557	327,107	50.00
53.00	05300	ANESTHESIOLOGY	-27,134	13,675	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	555,272	54.00
57.00	05700	CT SCAN	0	101,762	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	76,365	58.00
60.00	06000	LABORATORY	-480	1,264,483	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	33,519	63.00
65.00	06500	RESPIRATORY THERAPY	0	318,274	65.00
66.00	06600	PHYSICAL THERAPY	-14,704	181,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40,081	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,881	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	64,365	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-8,310	1,029,956	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	410,812	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,355,027	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	203,477	88.01
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-387,219	2,078,237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,492,737	18,000,917	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	344,902	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,492,737	18,345,819	200.00

RECLASSIFICATIONS

Provider CCN: 14-1321

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

Worksheet A-6

Date/Time Prepared:
11/18/2019 4:25 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA COST					
1.00	CAFETERIA	11.00	180,938	146,578		1.00
	0		180,938	146,578		
	B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	96,100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	68,449		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	140,519		3.00
	0		0	305,068		
	C - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	66,422		1.00
	0		0	66,422		
	E - TELEPHONE COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	50,323		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
	0		0	50,323		
	F - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	5,201		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	5,201		
	H - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,038,266		1.00
	0		0	1,038,266		
	J - CT SCAN COSTS					
1.00	CT SCAN	57.00	11,427	871		1.00
	0		11,427	871		
	K - BLOOD					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	3,754	286		1.00
	0		3,754	286		
	L - RHC BILLING					
1.00	ADMINISTRATIVE & GENERAL	5.00	25,819	1,579		1.00
	0		25,819	1,579		
500.00	Grand Total: Increases		221,938	1,614,594		500.00

RECLASSIFICATIONS

Provider CCN: 14-1321

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

Worksheet A-6

Date/Time Prepared:
11/18/2019 4:25 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA COST					
1.00	DIETARY	10.00	180,938	146,578	0	1.00
	0		180,938	146,578		
	B - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	305,068	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	0		0	305,068		
	C - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,422	0	1.00
	0		0	66,422		
	E - TELEPHONE COSTS					
1.00	MAINTENANCE & REPAIRS	6.00	0	371	0	1.00
2.00	OPERATION OF PLANT	7.00	0	30,968	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	316	0	3.00
4.00	RURAL HEALTH CLINIC	88.00	0	9,562	0	4.00
5.00	RURAL HEALTH CLINIC II	88.01	0	9,106	0	5.00
	0		0	50,323		
	F - OXYGEN COSTS					
1.00	OPERATING ROOM	50.00	0	21	0	1.00
2.00	ANESTHESIOLOGY	53.00	0	287	0	2.00
3.00	RESPIRATORY THERAPY	65.00	0	4,893	0	3.00
	0		0	5,201		
	H - DRUGS CHARGED TO PATIENTS					
1.00	PHARMACY	15.00	0	1,038,266	0	1.00
	0		0	1,038,266		
	J - CT SCAN COSTS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	11,427	871	0	1.00
	0		11,427	871		
	K - BLOOD					
1.00	LABORATORY	60.00	3,754	286	0	1.00
	0		3,754	286		
	L - RHC BILLING					
1.00	RURAL HEALTH CLINIC	88.00	25,819	1,579	0	1.00
	0		25,819	1,579		
500.00	Grand Total: Decreases		221,938	1,614,594		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

		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	18,401	0	0	0	0	1.00	
2.00	Land Improvements	126,550	18,589	0	18,589	0	2.00	
3.00	Buildings and Fixtures	4,460,832	950,000	0	950,000	0	3.00	
4.00	Building Improvements	5,310,843	5,000	0	5,000	0	4.00	
5.00	Fixed Equipment	3,247,041	0	0	0	0	5.00	
6.00	Movable Equipment	7,147,574	338,911	0	338,911	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	20,311,241	1,312,500	0	1,312,500	0	8.00	
9.00	Reconciling Items	-85,710	-950,023	0	-950,023	0	9.00	
10.00	Total (line 8 minus line 9)	20,396,951	2,262,523	0	2,262,523	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	18,401	0				1.00	
2.00	Land Improvements	145,139	0				2.00	
3.00	Buildings and Fixtures	5,410,832	0				3.00	
4.00	Building Improvements	5,315,843	0				4.00	
5.00	Fixed Equipment	3,247,041	0				5.00	
6.00	Movable Equipment	7,486,485	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	21,623,741	0				8.00	
9.00	Reconciling Items	-1,035,733	0				9.00	
10.00	Total (line 8 minus line 9)	22,659,474	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part II
Date/Time Prepared:
11/18/2019 4:25 pm

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	134,106	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	543,504	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	677,610	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	134,106				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	543,504				2.00
3.00	Total (sum of lines 1-2)	0	677,610				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet A-7
Part III
Date/Time Prepared:
11/18/2019 4:25 pm

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	14,137,256	0	14,137,256	0.653784	43,426	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,486,485	0	7,486,485	0.346216	22,996	2.00
3.00	Total (sum of lines 1-2)	21,623,741	0	21,623,741	1.000000	66,422	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	43,426	134,106	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	22,996	359,992	0	2.00
3.00	Total (sum of lines 1-2)	0	0	66,422	494,098	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	95,731	43,426	0	0	273,263	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	68,186	22,996	0	0	451,174	2.00
3.00	Total (sum of lines 1-2)	163,917	66,422	0	0	724,437	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1321

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

Worksheet A-8

Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-369	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-263	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-539	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-19,987	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,562	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,554	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-727,705			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-981	ADMINISTRATIVE & GENERAL	5.00	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	-107,244	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-8,310	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,205	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	-14,704	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-183,512	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	NH UTILITIES	B	-100,373	OPERATION OF PLANT	7.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1321

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

Worksheet A-8

Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	MISCELLANEOUS INCOME	B		6 ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	OTHER INCOME	B	-480	LABORATORY	60.00	0	34.01
35.00	LOBBYING PORTION OF DUES	A	-6,023	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	340B RETAIL PHARMACY COSTS	A	-267,617	PHARMACY	15.00	0	36.00
37.00	ADVERTISING	A	-26,507	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PHYSICIAN BENEFITS	A	-10,794	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	PHYSICIAN FICA	A	-6,014	ADULTS & PEDIATRICS	30.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,492,737				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: 14-1321

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

Worksheet A-8-2

Date/Time Prepared:
11/18/2019 4:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	265,795	265,795	0	0	0	1.00
2.00	50.00	OPERATING ROOM	47,557	47,557	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	27,134	27,134	0	0	0	3.00
4.00	60.00	LABORATORY	24,195	0	24,195	0	0	4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,000	0	36,000	0	0	5.00
6.00	91.00	EMERGENCY	1,547,461	387,219	1,160,242	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			1,948,142	727,705	1,220,437		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	265,795		1.00
2.00	50.00	OPERATING ROOM	0	0	0	47,557		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	27,134		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		5.00
6.00	91.00	EMERGENCY	0	0	0	387,219		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	727,705		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2019 4:25 pm	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					264	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					101	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.63	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	658.89	1,686.38	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	83.61	62.70	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.81	41.81	31.35			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					55,090	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					105,736	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					160,826	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					160,826	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					160,826	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					11,038	24.00
25.00	Assistants (line 4 times column 3, line 11)					3,166	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					14,204	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,055	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					16,259	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					16,259	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
11/18/2019 4:25 pm

					Physical Therapy	Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	83.61	62.70	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					160,826	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					16,259	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					177,085	63.00
64.00	Total cost of outside supplier services (from your records)					191,789	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					14,704	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					14,204	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,055	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					16,259	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					2,055	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					2,055	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2019 4:25 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					166	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.63	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	313.19	133.47	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.23	59.43	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.62	39.62	29.72			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
							1.00
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					24,814	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					7,932	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					32,746	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					32,746	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					73.31	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					57,182	22.00
23.00	Total salary equivalency (see instructions)					57,182	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					6,577	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					6,577	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					935	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					7,512	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					7,512	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2019 4:25 pm		
				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	79.23	59.43	0.00	0.00		52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00	
						1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						57,182	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						7,512	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						64,694	63.00
64.00	Total cost of outside supplier services (from your records)						36,187	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						6,577	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						935	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						7,512	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						935	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						935	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/18/2019 4:25 pm	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					149	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.63	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	148.55	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.14	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.07	38.07	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					11,311	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					11,311	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					11,311	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					76.14	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					59,389	22.00
23.00	Total salary equivalency (see instructions)					59,389	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					5,672	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					5,672	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					839	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,511	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					6,511	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY
OUTSIDE SUPPLIERS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet A-8-3
Parts I-VI
Date/Time Prepared:
11/18/2019 4:25 pm

				Speech Pathology	11/10/2010 4:10 pm		Cost		
							1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00	
				Therapists	Assistants	Aides	Trainees	Total	
				1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.14	0.00	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	0	55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	0	56.00	
							1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)						59,389	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						6,511	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00	
60.00	Overtime allowance (from column 5, line 56)						0	60.00	
61.00	Equipment cost (see instructions)						0	61.00	
62.00	Supplies (see instructions)						0	62.00	
63.00	Total allowance (sum of lines 57-62)						65,900	63.00	
64.00	Total cost of outside supplier services (from your records)						10,880	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						5,672	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						839	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27						6,511	100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						839	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01	
101.02	Line 34 = sum of lines 27 and 31						839	101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01	
102.02	Line 35 = sum of lines 31 and 32						0	102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	273,263	273,263			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	451,174		451,174		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,143,518	647	0	2,144,165	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,691,986	30,144	11,699	377,268	5.00
6.00	00600	MAINTENANCE & REPAIRS	345,912	9,332	4,294	60,704	6.00
7.00	00700	OPERATION OF PLANT	260,740	29,913	25,358	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,943	2,564	0	0	8.00
9.00	00900	HOUSEKEEPING	267,709	1,376	0	58,022	9.00
10.00	01000	DIETARY	63,143	16,958	284	9,051	10.00
11.00	01100	CAFETERIA	220,272	0	0	46,948	11.00
13.00	01300	NURSING ADMINISTRATION	481,039	2,458	0	115,201	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	99,727	8,657	0	23,322	14.00
15.00	01500	PHARMACY	301,198	3,646	0	55,356	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	267,990	3,596	4,082	51,561	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	993,463	21,205	63,296	180,035	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	327,107	24,133	15,564	42,425	50.00
53.00	05300	ANESTHESIOLOGY	13,675	353	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	555,272	9,285	160,400	108,135	54.00
57.00	05700	CT SCAN	101,762	2,129	116,231	2,965	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	76,365	0	0	0	58.00
60.00	06000	LABORATORY	1,264,483	6,709	6,233	112,177	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	33,519	0	0	974	63.00
65.00	06500	RESPIRATORY THERAPY	318,274	3,478	6,505	65,027	65.00
66.00	06600	PHYSICAL THERAPY	181,547	4,011	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,081	627	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,881	200	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	64,365	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,029,956	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	410,812	11,386	0	54,184	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,355,027	33,636	0	499,954	88.00
88.01	08801	RURAL HEALTH CLINIC II	203,477	5,187	14,926	37,596	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,078,237	8,724	22,302	162,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,000,917	240,354	451,174	2,063,859	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	344,902	32,909	0	80,306	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	18,345,819	273,263	451,174	2,144,165	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,111,097					5.00
6.00	00600	MAINTENANCE & REPAIRS	85,818	506,060				6.00
7.00	00700	OPERATION OF PLANT	64,533	64,930	445,474			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,828	5,566	5,621	104,522		8.00
9.00	00900	HOUSEKEEPING	66,799	2,987	3,017	0	399,910	9.00
10.00	01000	DIETARY	18,264	36,810	37,172	0	0	10.00
11.00	01100	CAFETERIA	54,569	0	0	0	14,471	11.00
13.00	01300	NURSING ADMINISTRATION	122,261	5,336	5,389	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	26,896	18,792	18,977	0	10,142	14.00
15.00	01500	PHARMACY	73,557	7,915	7,993	1,172	8,531	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,824	7,805	7,881	0	3,349	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	256,897	46,027	46,480	23,509	72,070	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	83,569	52,385	52,901	8,886	32,575	50.00
53.00	05300	ANESTHESIOLOGY	2,865	766	774	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,127	20,154	20,352	12,872	13,744	54.00
57.00	05700	CT SCAN	45,557	4,621	4,667	2,698	3,160	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	15,595	0	0	0	0	58.00
60.00	06000	LABORATORY	283,772	14,562	14,706	0	16,019	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	7,044	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	80,313	7,549	7,624	636	15,071	65.00
66.00	06600	PHYSICAL THERAPY	37,893	8,707	8,792	7,705	15,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,313	1,362	1,375	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,263	434	438	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,144	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	210,328	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	97,282	24,716	24,959	1,084	13,144	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	589,884	73,007	73,726	3,282	66,731	88.00
88.01	08801	RURAL HEALTH CLINIC II	53,337	11,260	11,371	1,334	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	464,012	18,937	19,123	38,585	84,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,017,544	434,628	373,338	101,763	369,704	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	93,553	71,432	72,136	2,759	30,206	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,111,097	506,060	445,474	104,522	399,910	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & 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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	181,682					10.00
11.00	01100	CAFETERIA	0	336,260				11.00
13.00	01300	NURSING ADMINISTRATION	0	23,102	754,786			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	7,156	0	213,669		14.00
15.00	01500	PHARMACY	0	8,751	47,651	962	516,732	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,252	104,831	665	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	127,856	47,682	259,642	5,470	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	11,240	61,205	26,274	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	37	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,075	0	2,064	0	54.00
57.00	05700	CT SCAN	0	856	0	2,968	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	36,753	0	124,865	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	311	0	1,447	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	16,762	0	2,900	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	796	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	15,426	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	516,732	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	53,826	14,390	78,359	342	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	72,493	0	15,573	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,424	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	37,297	203,098	11,696	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,682	327,120	754,786	212,909	516,732	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	9,140	0	760	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	181,682	336,260	754,786	213,669	516,732	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	537,836				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,397	2,157,029	0	2,157,029	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	21,497	759,761	0	759,761	50.00
53.00	05300	ANESTHESIOLOGY	518	18,988	0	18,988	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,027	1,147,507	0	1,147,507	54.00
57.00	05700	CT SCAN	76,521	364,135	0	364,135	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,254	96,214	0	96,214	58.00
60.00	06000	LABORATORY	132,219	2,012,498	0	2,012,498	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,134	44,429	0	44,429	63.00
65.00	06500	RESPIRATORY THERAPY	24,788	548,927	0	548,927	65.00
66.00	06600	PHYSICAL THERAPY	16,499	281,653	0	281,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,587	54,345	0	54,345	67.00
68.00	06800	SPEECH PATHOLOGY	830	15,046	0	15,046	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,209	97,144	0	97,144	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,253	1,821,269	0	1,821,269	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	18,403	802,887	0	802,887	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	38,369	3,821,682	0	3,821,682	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,109	342,021	0	342,021	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	72,222	3,222,181	0	3,222,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	537,836	17,607,716	0	17,607,716	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	738,103	0	738,103	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	537,836	18,345,819	0	18,345,819	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/18/2019 4:25 pm

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	647	0	647	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,795	30,144	11,699	47,638	5.00
6.00	00600	MAINTENANCE & REPAIRS	183	9,332	4,294	13,809	6.00
7.00	00700	OPERATION OF PLANT	31	29,913	25,358	55,302	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,564	0	2,564	8.00
9.00	00900	HOUSEKEEPING	0	1,376	0	1,376	9.00
10.00	01000	DIETARY	0	16,958	284	17,242	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,458	0	2,458	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,135	8,657	0	9,792	14.00
15.00	01500	PHARMACY	3	3,646	0	3,649	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,276	3,596	4,082	8,954	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,882	21,205	63,296	89,383	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,371	24,133	15,564	62,068	50.00
53.00	05300	ANESTHESIOLOGY	1,561	353	0	1,914	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	363	9,285	160,400	170,048	54.00
57.00	05700	CT SCAN	0	2,129	116,231	118,360	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	49,311	6,709	6,233	62,253	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,123	3,478	6,505	19,106	65.00
66.00	06600	PHYSICAL THERAPY	66	4,011	0	4,077	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	627	0	627	67.00
68.00	06800	SPEECH PATHOLOGY	0	200	0	200	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	67	11,386	0	11,453	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	932	33,636	0	34,568	88.00
88.01	08801	RURAL HEALTH CLINIC II	64	5,187	14,926	20,177	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	981	8,724	22,302	32,007	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,144	240,354	451,174	789,672	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	359	32,909	0	33,268	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	98,503	273,263	451,174	822,940	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	47,751					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,317	15,144				6.00
7.00	00700	OPERATION OF PLANT	990	1,943	58,235			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	243	167	735	3,709		8.00
9.00	00900	HOUSEKEEPING	1,025	89	394	0	2,901	9.00
10.00	01000	DIETARY	280	1,102	4,859	0	0	10.00
11.00	01100	CAFETERIA	837	0	0	0	105	11.00
13.00	01300	NURSING ADMINISTRATION	1,876	160	704	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	413	562	2,481	0	74	14.00
15.00	01500	PHARMACY	1,129	237	1,045	42	62	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,026	234	1,030	0	24	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,943	1,377	6,076	834	523	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,283	1,568	6,915	315	236	50.00
53.00	05300	ANESTHESIOLOGY	44	23	101	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,611	603	2,661	457	100	54.00
57.00	05700	CT SCAN	699	138	610	96	23	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	239	0	0	0	0	58.00
60.00	06000	LABORATORY	4,355	436	1,922	0	116	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	108	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,233	226	997	23	109	65.00
66.00	06600	PHYSICAL THERAPY	582	261	1,149	273	114	66.00
67.00	06700	OCCUPATIONAL THERAPY	128	41	180	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35	13	57	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	202	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,228	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,493	740	3,263	38	95	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	9,056	2,182	9,640	116	484	88.00
88.01	08801	RURAL HEALTH CLINIC II	819	337	1,486	47	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,121	567	2,500	1,370	617	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	46,315	13,006	48,805	3,611	2,682	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,436	2,138	9,430	98	219	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	47,751	15,144	58,235	3,709	2,901	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & 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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	23,486					10.00
11.00	01100	CAFETERIA	0	956				11.00
13.00	01300	NURSING ADMINISTRATION	0	66	5,299			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	20	0	13,349		14.00
15.00	01500	PHARMACY	0	25	335	60	6,601	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	55	736	42	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	16,528	136	1,822	342	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	32	430	1,641	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88	0	129	0	54.00
57.00	05700	CT SCAN	0	2	0	185	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	104	0	7,802	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1	0	90	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	48	0	181	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	50	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	964	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	6,601	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,958	41	550	21	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	206	0	973	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	89	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	106	1,426	731	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,486	930	5,299	13,302	6,601	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26	0	47	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	23,486	956	5,299	13,349	6,601	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet B
Part II
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICE & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,116				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	302	121,320	0	121,320	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	484	74,985	0	74,985	50.00
53.00	05300	ANESTHESIOLOGY	12	2,096	0	2,096	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	991	177,721	0	177,721	54.00
57.00	05700	CT SCAN	1,722	121,836	0	121,836	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96	335	0	335	58.00
60.00	06000	LABORATORY	2,986	80,008	0	80,008	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	26	225	0	225	63.00
65.00	06500	RESPIRATORY THERAPY	558	22,501	0	22,501	65.00
66.00	06600	PHYSICAL THERAPY	371	6,877	0	6,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	58	1,034	0	1,034	67.00
68.00	06800	SPEECH PATHOLOGY	19	324	0	324	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95	1,261	0	1,261	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,446	11,275	0	11,275	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	414	25,082	0	25,082	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	864	58,242	0	58,242	88.00
88.01	08801	RURAL HEALTH CLINIC II	47	23,013	0	23,013	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,625	48,119	0	48,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,116	776,254	0	776,254	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	46,686	0	46,686	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,116	822,940	0	822,940	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1321

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

Worksheet B-1

Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	69,693					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		428,441				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	165	0	8,263,619			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,688	11,110	1,453,993	-3,111,097	15,234,722	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,380	4,078	233,952	0	420,242	6.00
7.00	00700	OPERATION OF PLANT	7,629	24,080	0	0	316,011	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	0	0	0	77,507	8.00
9.00	00900	HOUSEKEEPING	351	0	223,617	0	327,107	9.00
10.00	01000	DIETARY	4,325	270	34,884	0	89,436	10.00
11.00	01100	CAFETERIA	0	0	180,938	0	267,220	11.00
13.00	01300	NURSING ADMINISTRATION	627	0	443,984	0	598,698	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,208	0	89,883	0	131,706	14.00
15.00	01500	PHARMACY	930	0	213,344	0	360,200	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	3,876	198,715	0	327,229	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,408	60,107	693,857	0	1,257,999	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,155	14,780	163,506	0	409,229	50.00
53.00	05300	ANESTHESIOLOGY	90	0	0	0	14,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368	152,317	416,752	0	833,092	54.00
57.00	05700	CT SCAN	543	110,375	11,427	0	223,087	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	76,365	58.00
60.00	06000	LABORATORY	1,711	5,919	432,330	0	1,389,602	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	3,754	0	34,493	63.00
65.00	06500	RESPIRATORY THERAPY	887	6,177	250,616	0	393,284	65.00
66.00	06600	PHYSICAL THERAPY	1,023	0	0	0	185,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	160	0	0	0	40,708	67.00
68.00	06800	SPEECH PATHOLOGY	51	0	0	0	11,081	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	64,365	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,029,956	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,904	0	208,824	0	476,382	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	8,578	0	1,926,818	0	2,888,617	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	14,174	144,895	0	261,186	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,225	21,178	628,028	0	2,272,217	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,300	428,441	7,954,117	-3,111,097	14,776,605	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,393	0	309,502	0	458,117	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	273,263	451,174	2,144,165		3,111,097	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.920953	1.053060	0.259470		0.204211	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			647		47,751	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000078		0.003134	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: 14-1321

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

Worksheet B-1

Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	59,460				6.00
7.00	00700	OPERATION OF PLANT	7,629	51,831			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	654	70,883		8.00
9.00	00900	HOUSEKEEPING	351	351	0	12,657	9.00
10.00	01000	DIETARY	4,325	4,325	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	458	11.00
13.00	01300	NURSING ADMINISTRATION	627	627	0	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2,208	2,208	0	321	14.00
15.00	01500	PHARMACY	930	930	795	270	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	917	0	106	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,408	5,408	15,943	2,281	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,155	6,155	6,026	1,031	50.00
53.00	05300	ANESTHESIOLOGY	90	90	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,368	2,368	8,729	435	54.00
57.00	05700	CT SCAN	543	543	1,830	100	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	1,711	1,711	0	507	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	887	887	431	477	65.00
66.00	06600	PHYSICAL THERAPY	1,023	1,023	5,225	497	66.00
67.00	06700	OCCUPATIONAL THERAPY	160	160	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	51	51	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,904	2,904	735	416	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,578	8,578	2,226	2,112	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	1,323	905	0	88.01
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,225	2,225	26,167	2,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,067	43,438	69,012	11,701	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,393	8,393	1,871	956	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	506,060	445,474	104,522	399,910	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.510932	8.594741	1.474571	31.595955	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,144	58,235	3,709	2,901	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.254692	1.123555	0.052326	0.229201	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: 14-1321

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

Worksheet B-1

Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICE & 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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,646					11.00
13.00	01300	NURSING ADMINISTRATION	594	3,564				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	184	0	891,532			14.00
15.00	01500	PHARMACY	225	225	4,016	1,038,266		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	495	495	2,774	0	40,618,857	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,226	1,226	22,822	0	1,011,781	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	289	289	109,628	0	1,623,500	50.00
53.00	05300	ANESTHESIOLOGY	0	0	156	0	39,114	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	799	0	8,614	0	3,325,016	54.00
57.00	05700	CT SCAN	22	0	12,385	0	5,779,108	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	321,311	58.00
60.00	06000	LABORATORY	945	0	520,996	0	9,985,455	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	8	0	6,036	0	85,636	63.00
65.00	06500	RESPIRATORY THERAPY	431	0	12,100	0	1,872,082	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,320	0	1,246,076	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	195,405	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1	0	62,690	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	64,365	0	317,888	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,038,266	4,852,571	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	370	370	1,426	0	1,389,812	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,864	0	64,977	0	2,897,712	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	5,943	0	159,251	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	959	959	48,803	0	5,454,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,411	3,564	888,362	1,038,266	40,618,857	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	235	0	3,170	0	0	192.00
194.00	07950	340B RETAIL PHARMACY	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	336,260	754,786	213,669	516,732	537,836	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.891973	211.780584	0.239665	0.497687	0.013241	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	956	5,299	13,349	6,601	12,116	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.110571	1.486813	0.014973	0.006358	0.000298	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,157,029		2,157,029	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	759,761		759,761	0	0	50.00
53.00	05300	ANESTHESIOLOGY	18,988		18,988	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,147,507		1,147,507	0	0	54.00
57.00	05700	CT SCAN	364,135		364,135	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,214		96,214	0	0	58.00
60.00	06000	LABORATORY	2,012,498		2,012,498	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	44,429		44,429	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	548,927	0	548,927	0	0	65.00
66.00	06600	PHYSICAL THERAPY	281,653	0	281,653	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	54,345	0	54,345	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,046	0	15,046	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	97,144		97,144	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,821,269		1,821,269	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	802,887		802,887	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,821,682		3,821,682	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	342,021		342,021	0	0	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,222,181		3,222,181	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92,066		92,066	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,699,782	0	17,699,782	0	0	200.00
201.00		Less Observation Beds	92,066		92,066			201.00
202.00		Total (see instructions)	17,607,716	0	17,607,716	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet C Part I Date/Time Prepared: 11/18/2019 4:25 pm	
					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	978,222		978,222			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,200	1,616,300	1,623,500	0.467977	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	39,114	39,114	0.485453	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,030	3,266,986	3,325,016	0.345113	0.000000	54.00
57.00	05700	CT SCAN	248,592	5,530,516	5,779,108	0.063009	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	321,311	321,311	0.299442	0.000000	58.00
60.00	06000	LABORATORY	557,378	9,428,077	9,985,455	0.201543	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	19,270	66,366	85,636	0.518812	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	563,135	1,308,947	1,872,082	0.293217	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	277,447	968,629	1,246,076	0.226032	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,858	77,547	195,405	0.278115	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	23,289	39,401	62,690	0.240006	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	153,226	164,662	317,888	0.305592	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	482,045	4,370,526	4,852,571	0.375320	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,389,812	1,389,812	0.577695	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	2,897,712	2,897,712			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	159,251	159,251			88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	60,192	5,394,257	5,454,449	0.590744	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	33,559	33,559	2.743407	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,545,884	37,072,973	40,618,857			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,545,884	37,072,973	40,618,857			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet C
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
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
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part II Date/Time Prepared: 11/18/2019 4:25 pm	
				Title XVIII		Hospital		Cost	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		74,985	1,623,500	0.046187	3,425	158	50.00
53.00	05300	ANESTHESIOLOGY		2,096	39,114	0.053587	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		177,721	3,325,016	0.053450	27,749	1,483	54.00
57.00	05700	CT SCAN		121,836	5,779,108	0.021082	118,079	2,489	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		335	321,311	0.001043	0	0	58.00
60.00	06000	LABORATORY		80,008	9,985,455	0.008012	284,159	2,277	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		225	85,636	0.002627	9,552	25	63.00
65.00	06500	RESPIRATORY THERAPY		22,501	1,872,082	0.012019	316,248	3,801	65.00
66.00	06600	PHYSICAL THERAPY		6,877	1,246,076	0.005519	63,938	353	66.00
67.00	06700	OCCUPATIONAL THERAPY		1,034	195,405	0.005292	24,462	129	67.00
68.00	06800	SPEECH PATHOLOGY		324	62,690	0.005168	10,019	52	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,261	317,888	0.003967	87,782	348	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		11,275	4,852,571	0.002324	250,607	582	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		25,082	1,389,812	0.018047	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		58,242	2,897,712	0.020099	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II		23,013	159,251	0.144508	0	0	88.01
90.00	09000	CLINIC		0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY		48,119	5,454,449	0.008822	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		5,178	33,559	0.154295	0	0	92.00
200.00		Total (lines 50 through 199)		660,112	39,640,635		1,196,020	11,697	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1321

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

Worksheet D
Part IV
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description			Title XVIII		Hospital		Cost	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
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
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-1321		Period: From 07/01/2018 To 06/30/2019		Worksheet D Part IV Date/Time Prepared: 11/18/2019 4:25 pm	
				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	1,623,500	0.000000	50.00
53.00	05300	ANESTHESIOLOGY		0	0	0	39,114	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	3,325,016	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	5,779,108	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	321,311	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	9,985,455	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		0	0	0	85,636	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	1,872,082	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	1,246,076	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	195,405	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	62,690	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	317,888	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	4,852,571	0.000000	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	1,389,812	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	2,897,712	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II		0	0	0	159,251	0.000000	88.01
90.00	09000	CLINIC		0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY		0	0	0	5,454,449	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	33,559	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	39,640,635		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part IV
Date/Time Prepared:
11/18/2019 4:25 pm

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	3,425	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	27,749	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	118,079	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	284,159	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	9,552	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	316,248	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	63,938	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	24,462	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,019	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	87,782	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	250,607	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	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
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	88.01
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
200.00		Total (lines 50 through 199)		1,196,020	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/18/2019 4:25 pm

			Title XVIII		Hospital		11/10/2019 4:25 pm 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	0.467977	0	950,959	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.485453	0	23,469	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.345113	0	1,115,199	0	0	54.00
57.00	05700	CT SCAN	0.063009	0	2,107,954	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.299442	0	127,813	0	0	58.00
60.00	06000	LABORATORY	0.201543	0	3,332,093	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.518812	0	47,157	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.293217	0	623,575	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.226032	0	273,689	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.278115	0	19,215	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.240006	0	1,126	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.305592	0	82,036	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.375320	0	2,521,628	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.577695	0	1,351,046	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.590744	0	1,747,477	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.743407	0	17,661	0	0	92.00
200.00		Subtotal (see instructions)		0	14,342,097	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	14,342,097	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet D
Part V
Date/Time Prepared:
11/18/2019 4:25 pm

				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	445,027	0		50.00
53.00	05300	ANESTHESIOLOGY	11,393	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	384,870	0		54.00
57.00	05700	CT SCAN	132,820	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	38,273	0		58.00
60.00	06000	LABORATORY	671,560	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	24,466	0		63.00
65.00	06500	RESPIRATORY THERAPY	182,843	0		65.00
66.00	06600	PHYSICAL THERAPY	61,862	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,344	0		67.00
68.00	06800	SPEECH PATHOLOGY	270	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,070	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	946,417	0		73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	780,493	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	1,032,312	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	48,451	0		92.00
200.00		Subtotal (see instructions)	4,791,471	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,791,471	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1321

Period:

Worksheet D

Component CCN: 14-Z321

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/18/2019 4:25 pm

			Title XVIII	Swing Beds - SNF		Cost		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.467977	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.485453	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.345113	0	0	0	0	54.00
57.00	05700	CT SCAN	0.063009	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.299442	0	0	0	0	58.00
60.00	06000	LABORATORY	0.201543	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.518812	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.293217	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.226032	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.278115	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.240006	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.305592	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.375320	0	0	0	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.577695	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.590744	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.743407	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1321

Period:

Worksheet D

Component CCN: 14-Z321

From 07/01/2018
To 06/30/2019Part V
Date/Time Prepared:
11/18/2019 4:25 pm

			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
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0					63.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0					76.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0					88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0					88.01
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
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: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet D-1 Date/Time Prepared: 11/18/2019 4:25 pm
		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)		880	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		563	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)		526	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		159	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)		144	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		5	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)		9	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		385	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)		154	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)		129	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,157,029	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)		786	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		1,415	25.00
26.00	Total swing-bed cost (see instructions)		756,141	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,400,888	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,400,888	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		2,488.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		957,976	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)		957,976	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1321

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

Worksheet D-1

Date/Time Prepared:
11/18/2019 4:25 pm

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)					318,118	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,276,094	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)					383,191	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					320,984	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					704,175	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)					2,488.26	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					92,066	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1321

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

Worksheet D-1

Date/Time Prepared:
11/18/2019 4:25 pm

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	121,320	2,157,029	0.056244	92,066	5,178
91.00	Nursing School cost	0	2,157,029	0.000000	92,066	0
92.00	Allied health cost	0	2,157,029	0.000000	92,066	0
93.00	All other Medical Education	0	2,157,029	0.000000	92,066	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/18/2019 4:25 pm	
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		596,874		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.467977	3,425	1,603	50.00
53.00	05300 ANESTHESIOLOGY	0.485453	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.345113	27,749	9,577	54.00
57.00	05700 CT SCAN	0.063009	118,079	7,440	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.299442	0	0	58.00
60.00	06000 LABORATORY	0.201543	284,159	57,270	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.518812	9,552	4,956	63.00
65.00	06500 RESPIRATORY THERAPY	0.293217	316,248	92,729	65.00
66.00	06600 PHYSICAL THERAPY	0.226032	63,938	14,452	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.278115	24,462	6,803	67.00
68.00	06800 SPEECH PATHOLOGY	0.240006	10,019	2,405	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.305592	87,782	26,825	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.375320	250,607	94,058	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.577695	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.590744	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.743407	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,196,020	318,118	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,196,020		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1321 Component CCN: 14-Z321	Period: From 07/01/2018 To 06/30/2019	Worksheet D-3 Date/Time Prepared: 11/18/2019 4:25 pm	
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	0.467977	1,865	873	50.00
53.00	05300 ANESTHESIOLOGY	0.485453	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.345113	10,519	3,630	54.00
57.00	05700 CT SCAN	0.063009	2,234	141	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.299442	0	0	58.00
60.00	06000 LABORATORY	0.201543	97,873	19,726	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.518812	4,304	2,233	63.00
65.00	06500 RESPIRATORY THERAPY	0.293217	121,791	35,711	65.00
66.00	06600 PHYSICAL THERAPY	0.226032	161,839	36,581	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.278115	68,857	19,150	67.00
68.00	06800 SPEECH PATHOLOGY	0.240006	10,443	2,506	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.305592	36,572	11,176	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.375320	114,305	42,901	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.577695	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.590744	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.743407	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		630,602	174,628	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)		630,602		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet E Part B Date/Time Prepared: 11/18/2019 4:25 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,791,471	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)		4,791,471	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		4,839,386	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)		32,346	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,178,574	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)		2,628,466	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)		2,628,466	30.00
31.00	Primary payer payments		596	31.00
32.00	Subtotal (line 30 minus line 31)		2,627,870	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)		428,601	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		278,591	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		275,994	36.00
37.00	Subtotal (see instructions)		2,906,461	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,906,461	40.00
40.01	Sequestration adjustment (see instructions)		58,129	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,607,571	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		240,761	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: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet E-1
Part I
Date/Time Prepared:
11/18/2019 4:25 pm

		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		1,079,910		2,558,018	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	12/26/2018	181,109	3.01
3.02			0	06/13/2019	52,504	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	06/13/2019	16,678	06/06/2019	184,060	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)		-16,678		49,553	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)		1,063,232		2,607,571	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		114,191		240,761	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,177,423		2,848,332	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: 14-1321

Period:

Worksheet E-1

Component CCN: 14-Z321

From 07/01/2018
To 06/30/2019Part I
Date/Time Prepared:
11/18/2019 4:25 pm

		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		784,398		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	06/06/2019	26,585		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)		26,585		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)		810,983		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		59,208		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		870,191		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: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet E-1 Part II Date/Time Prepared: 11/18/2019 4:25 pm
		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: 14-1321 Component CCN: 14-Z321	Period: From 07/01/2018 To 06/30/2019	Worksheet E-2 Date/Time Prepared: 11/18/2019 4:25 pm
		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)	711,217	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)	176,374	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	283	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)	887,591	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	887,591	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)	887,591	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	512	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)	887,079	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)	1,340	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	871	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	887,950	0	19.00
19.01	Sequestration adjustment (see instructions)	17,759	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	810,983	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)	59,208	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: 14-1321	Period: From 07/01/2018 To 06/30/2019	Worksheet E-3 Part V Date/Time Prepared: 11/18/2019 4:25 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,276,094 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)			1,276,094 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,288,855 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,288,855 19.00
20.00	Deductibles (exclude professional component)			116,104 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,172,751 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,172,751 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			44,156 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			28,701 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			31,280 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,201,452 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)			1,201,452 30.00
30.01	Sequestration adjustment (see instructions)			24,029 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			1,063,232 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)			114,191 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: 14-1321

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

Worksheet G

Date/Time Prepared:
11/18/2019 4:25 pm

		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	1,019,197	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	3,129,973	0	0	0	4.00
5.00	Other receivable	892,358	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	347,975	0	0	0	7.00
8.00	Prepaid expenses	101,934	0	0	0	8.00
9.00	Other current assets	95,234	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)	5,586,671	0	0	0	11.00
FIXED ASSETS						
12.00	Land	18,401	0	0	0	12.00
13.00	Land improvements	146,139	0	0	0	13.00
14.00	Accumulated depreciation	-120,895	0	0	0	14.00
15.00	Buildings	5,410,832	0	0	0	15.00
16.00	Accumulated depreciation	-4,451,097	0	0	0	16.00
17.00	Leasehold improvements	5,315,843	0	0	0	17.00
18.00	Accumulated depreciation	-4,670,979	0	0	0	18.00
19.00	Fixed equipment	19,234	0	0	0	19.00
20.00	Accumulated depreciation	-4,140	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	10,713,292	0	0	0	23.00
24.00	Accumulated depreciation	-8,723,352	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	1,035,733	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	4,689,011	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	942,115	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	942,115	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,217,797	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,891,474	0	0	0	37.00
38.00	Salaries, wages, and fees payable	805,638	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,889,197	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	448,320	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,034,629	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	4,662,042	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)	4,662,042	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,696,671	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	1,521,126				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)	1,521,126	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,217,797	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1321

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

Worksheet G-1

Date/Time Prepared:
11/18/2019 4:25 pm

		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		927,536		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		593,590				2.00
3.00	Total (sum of line 1 and line 2)		1,521,126		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,521,126		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,521,126		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: 14-1321

Period:
From 07/01/2018
To 06/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
11/18/2019 4:25 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	807,757		807,757	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	163,207		163,207	5.00
6.00	Swing bed - NF	7,258		7,258	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	978,222		978,222	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)	978,222		978,222	17.00
18.00	Ancillary services	2,507,470	28,588,194	31,095,664	18.00
19.00	Outpatient services	60,192	5,427,816	5,488,008	19.00
20.00	RURAL HEALTH CLINIC	0	2,897,712	2,897,712	20.00
20.01	RURAL HEALTH CLINIC II	0	159,251	159,251	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	165,979	2,190,191	2,356,170	27.00
27.01	SPECIALTY CLINIC	0	276,541	276,541	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,711,863	39,539,705	43,251,568	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,838,556		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	INTEREST EXPENSE	305,068			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)		305,068		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,533,488		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1321

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

Worksheet G-3

Date/Time Prepared:
11/18/2019 4:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,251,568	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,651,296	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,600,272	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,533,488	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-933,216	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	89,548	6.00
7.00	Income from investments	31,065	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	19,987	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	107,244	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	8,310	17.00
18.00	Revenue from sale of medical records and abstracts	5,205	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	65,897	22.00
23.00	Governmental appropriations	870,381	23.00
24.00	340B DRUG PROGRAM	480,255	24.00
24.01	UTILITY REIMBURSEMENT	100,373	24.01
24.02	GRANT INCOME	38,984	24.02
24.03	MISC INCOME	14,625	24.03
25.00	Total other income (sum of lines 6-24)	1,831,874	25.00
26.00	Total (line 5 plus line 25)	898,658	26.00
27.00	INTEREST EXPENSE	305,068	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	305,068	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	593,590	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-3469

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/18/2019 4:25 pm

				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	744,913	0	744,913	0	744,913	1.00
2.00	Physician Assistant	126,146	0	126,146	0	126,146	2.00
3.00	Nurse Practitioner	383,091	0	383,091	0	383,091	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	377,799	0	377,799	0	377,799	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,631,949	0	1,631,949	0	1,631,949	10.00
11.00	Physician Services Under Agreement	0	126,486	126,486	0	126,486	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	126,486	126,486	0	126,486	14.00
15.00	Medical Supplies	0	64,977	64,977	0	64,977	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	12,926	12,926	0	12,926	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	77,903	77,903	0	77,903	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,631,949	204,389	1,836,338	0	1,836,338	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	78,573	78,573	0	78,573	29.00
30.00	Administrative Costs	320,688	156,388	477,076	-36,960	440,116	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	320,688	234,961	555,649	-36,960	518,689	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,952,637	439,350	2,391,987	-36,960	2,355,027	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-3469

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/18/2019 4:25 pm

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	744,913	1.00
2.00	Physician Assistant	0	126,146	2.00
3.00	Nurse Practitioner	0	383,091	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	377,799	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)	0	1,631,949	10.00
11.00	Physician Services Under Agreement	0	126,486	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	126,486	14.00
15.00	Medical Supplies	0	64,977	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	12,926	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	77,903	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,836,338	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	78,573	29.00
30.00	Administrative Costs	0	440,116	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	518,689	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,355,027	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-8510

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/18/2019 4:25 pm

		RHC II		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0 1.00
2.00	Physician Assistant	84,099	0	84,099	0	84,099 2.00
3.00	Nurse Practitioner	14,659	0	14,659	0	14,659 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	24,931	0	24,931	0	24,931 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	123,689	0	123,689	0	123,689 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	5,943	5,943	0	5,943 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	881	881	0	881 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,824	6,824	0	6,824 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	123,689	6,824	130,513	0	130,513 22.00
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0 23.00
24.00	Dental	0	0	0	0	0 24.00
25.00	Optometry	0	0	0	0	0 25.00
25.01	Telehealth	0	0	0	0	0 25.01
25.02	Chronic Care Management	0	0	0	0	0 25.02
26.00	All other nonreimbursable costs	0	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	19,644	19,644	0	19,644 29.00
30.00	Administrative Costs	21,206	41,220	62,426	-9,106	53,320 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	21,206	60,864	82,070	-9,106	72,964 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	144,895	67,688	212,583	-9,106	203,477 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1321

Period:

Worksheet M-1

Component CCN: 14-8510

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/18/2019 4:25 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC II	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	84,099		2.00
3.00	Nurse Practitioner	0	14,659		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	24,931		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)	0	123,689		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	5,943		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	881		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,824		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	130,513		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	19,644		29.00
30.00	Administrative Costs	0	53,320		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	72,964		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	203,477		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1321

Period:

Worksheet M-2

Component CCN: 14-3469

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/18/2019 4:25 pm

		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	2.83	9,841	4,200	11,886	1.00
2.00	Physician Assistant	1.57	2,143	2,100	3,297	2.00
3.00	Nurse Practitioner	3.11	6,038	2,100	6,531	3.00
4.00	Subtotal (sum of lines 1 through 3)	7.51	18,022		21,714	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)	7.51	18,022		21,714	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)				1,836,338	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)				1,836,338	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)				518,689	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				1,466,655	15.00
16.00	Total overhead (sum of lines 14 and 15)				1,985,344	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				1,985,344	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				1,985,344	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				3,821,682	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1321

Period:

Worksheet M-2

Component CCN: 14-8510

From 07/01/2018
To 06/30/2019Date/Time Prepared:
11/18/2019 4:25 pm

				RHC II		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	0.00	0	4,200	0		1.00
2.00	Physician Assistant	0.65	865	2,100	1,365		2.00
3.00	Nurse Practitioner	0.09	207	2,100	189		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.74	1,072		1,554	1,554	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)	0.74	1,072			1,554	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)					130,513	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)					130,513	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)					72,964	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					138,544	15.00
16.00	Total overhead (sum of lines 14 and 15)					211,508	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					211,508	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					211,508	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					342,021	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1321 Component CCN: 14-3469	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/18/2019 4:25 pm	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			3,821,682	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			54,947	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			3,766,735	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			21,714	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			21,714	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			173.47	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		173.47	173.47	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	6,904	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	1,197,637	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	1,197,637	16.00
16.01	Total program charges (see instructions)(from contractor's records)			1,207,110	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			52,242	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			51,833	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.)			851,119	16.04
16.05	Total program cost (see instructions)		0	902,952	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			81,905	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			214,592	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			902,952	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			42,292	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			945,244	22.00
23.00	Allowable bad debts (see instructions)			81,043	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			52,678	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			73,188	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)			997,922	26.00
26.01	Sequestration adjustment (see instructions)			19,958	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			943,615	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)			34,349	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1321 Component CCN: 14-8510	Period: From 07/01/2018 To 06/30/2019	Worksheet M-3 Date/Time Prepared: 11/18/2019 4:25 pm		
		Title XVIII	RHC II	Cost		
				1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES						
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			342,021	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			896	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			341,125	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			1,554	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)			1,554	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			219.51	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)			219.51	219.51	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	508	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	111,511	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	111,511	16.00
16.01	Total program charges (see instructions)(from contractor's records)				77,580	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				3,369	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				4,842	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.)				81,181	16.04
16.05	Total program cost (see instructions)			0	86,023	16.05
17.00	Primary payer amounts				0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				5,193	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				13,804	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				86,023	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				398	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				86,421	22.00
23.00	Allowable bad debts (see instructions)				1,678	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				1,091	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				1,645	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)				87,512	26.00
26.01	Sequestration adjustment (see instructions)				1,750	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				114,123	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)				-28,361	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: 14-1321 Component CCN: 14-3469	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/18/2019 4:25 pm	
		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)		1,631,949	1,631,949	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000384	0.000425	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		627	694	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		18,392	6,689	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		19,019	7,383	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,836,338	1,836,338	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,985,344	1,985,344	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010357	0.004021	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		20,562	7,983	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		39,581	15,366	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		176	195	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		224.89	78.80	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		139	140	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		31,260	11,032	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)			54,947	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)			42,292	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1321 Component CCN: 14-8510	Period: From 07/01/2018 To 06/30/2019	Worksheet M-4 Date/Time Prepared: 11/18/2019 4:25 pm	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		123,689	123,689	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000265	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	33	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	309	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	342	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		130,513	130,513	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		211,508	211,508	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.002620	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	554	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	896	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	9	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	99.56	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	4	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	398	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)			896	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)			398	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1321 Component CCN: 14-3469	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/18/2019 4:25 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		987,239	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		06/06/2019	43,624	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)		-43,624	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		943,615	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		34,349	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		977,964	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1321 Component CCN: 14-8510	Period: From 07/01/2018 To 06/30/2019	Worksheet M-5 Date/Time Prepared: 11/18/2019 4:25 pm	
			RHC II	Cost	
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC			74,703	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		06/06/2019		39,420	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)			39,420	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			114,123	4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program					
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6.01
6.02	SETTLEMENT TO PROGRAM			28,361	6.02
7.00	Total Medicare program liability (see instructions)			85,762	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00