

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet S Parts I-III Date/Time Prepared: 9/3/2019 12:25 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 9/3/2019	Time: 12:25 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 15101 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 MASSAC MEMORIAL HOSPITAL (14-1323) for the cost reporting period beginning 04/01/2018 and ending 03/31/2019 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) RICHARD GOINS

Officer or Administrator of Provider(s)

CEO

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	21,213	1,043,089	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	-160,967	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		1,365		0	10.00
200.00	Total	0	-139,754	1,044,454	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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part I
Date/Time Prepared:
9/3/2019 12:25 am

1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 28 CHICK STREET			PO Box:						1.00
2.00	City: METROPOLIS			State: IL		Zip Code: 62960-		County: MASSAC		2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MASSAC MEMORIAL HOSPITAL	141323	99914	1	02/01/2003	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					04/01/2018	03/31/2019		20.00	
21.00	Type of Control (see instructions)					11			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.				3	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00
					Urban/Rural S 1.00	Date of Geogr 2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning: 1.00	Ending: 2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N 1.00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V 1.00	XVIII 2.00	XIX 3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.							
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: 14-1323		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 9/3/2019 12:25 am			
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
			1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00		
			Y/N	IME	Direct GME	IME	Direct GME		
			1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00		
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06		
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
			1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20		
							1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)									
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings									
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
				1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	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
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 9/3/2019 12:25 am	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					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: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part I Date/Time Prepared: 9/3/2019 12:25 am	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	107,124	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1323		Period: From 04/01/2018 To 03/31/2019		Worksheet S-2 Part I Date/Time Prepared: 9/3/2019 12:25 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	Contractor's Name:		Contractor's Number:						
142.00	Street:	PO Box:								
143.00	City:	State:		Zip Code:						
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	
								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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC		N	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	166.00		
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									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)						10/01/2013	09/30/2014	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: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet S-2 Part II Date/Time Prepared: 9/3/2019 12:25 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	08/31/2019
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/27/2019	Y
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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
9/3/2019 12:25 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		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.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	LEE		41.00
42.00	Enter the employer/company name of the cost report preparer.	MEDTRACK, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953	KYLE.LEE@EDPTS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet S-2
Part II
Date/Time Prepared:
9/3/2019 12:25 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRIN		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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
9/3/2019 12:25 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	79,251.61	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	79,251.61	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	79,251.61	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
9/3/2019 12:25 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,147	229	2,930			1.00
2.00	HMO and other (see instructions)	168	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	603	0	603			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		161	161			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,750	390	3,694			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)	2,750	390	3,694	0.00	167.33	14.00
15.00	CAH visits	8,768	0	23,553			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	2,296	0	9,671	0.00	12.50	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	179.83	27.00
28.00	Observation Bed Days		0	322			28.00
29.00	Ambulance Trips	924					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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet S-3
Part I
Date/Time Prepared:
9/3/2019 12:25 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	562	60	782	1.00
2.00 HMO and other (see instructions)			45	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	562	60	782	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

Health Financial Systems		MASSAC MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 14-1323 Component CCN: 14-3478		Period: From 04/01/2018 To 03/31/2019 Worksheet S-8 Date/Time Prepared: 9/3/2019 12:25 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	Street	28 CHICK STREET		1.00	
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	METROPOLIS		IL 62960	2.00
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00
		Grant Award		Date	
		1.00		2.00	
Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00	
7.00	Appalachian Regional Commission			7.00	
8.00	Look-Alikes			8.00	
9.00	OTHER (SPECIFY)			9.00	
		1.00		2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N		0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00	
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N		0	13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number			Total Visits	14.00
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			15.00	
		County			
		4.00			
2.00	City, State, ZIP Code, County	MASSAC		2.00	
		Tuesday	Wednesday	Thursday	
		to	from	to	from
		6.00	7.00	8.00	9.00
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00
		17:00		08:00	17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1323

Period:

Worksheet S-8

Component CCN: 14-3478

From 04/01/2018
To 03/31/2019Date/Time Prepared:
9/3/2019 12:25 am

RHC I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet S-10 Date/Time Prepared: 9/3/2019 12:25 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.460778		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,135,248		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		13,515,194		6.00
7.00	Medicaid cost (line 1 times line 6)		6,227,504		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)		4,092,256		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)		4,092,256		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)	244,863	0	244,863	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	112,827	0	112,827	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)	112,827	0	112,827	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)		2,068,654		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		684,557		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,053,163		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,015,491		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		836,522		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		949,349		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,041,605		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet A

Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		903,538		274,397	1,177,935
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	0	0
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	0	0
2.00	00200	CAP REL COSTS-MVBLE EQUIP		866,170		122,465	988,635
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,315,079		0	4,315,079
5.00	00500	ADMINISTRATIVE & GENERAL	1,265,234	2,124,928	3,390,162	-55,110	3,335,052
7.00	00700	OPERATION OF PLANT	234,021	899,426	1,133,447	-538	1,132,909
8.00	00800	LAUNDRY & LINEN SERVICE	14,879	108,179	123,058	0	123,058
9.00	00900	HOUSEKEEPING	296,965	65,422	362,387	0	362,387
10.00	01000	DIETARY	309,359	210,448	519,807	-258,653	261,154
11.00	01100	CAFETERIA	0	0	0	258,426	258,426
13.00	01300	NURSING ADMINISTRATION	252,483	12,967	265,450	-3,719	261,731
16.00	01600	MEDICAL RECORDS & LIBRARY	226,506	62,435	288,941	-3,232	285,709
17.00	01700	SOCIAL SERVICE	170,856	11,368	182,224	0	182,224
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	366,705	366,705
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,294,151	262,803	1,556,954	467,423	2,024,377
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	272,583	823,958	1,096,541	-394,550	701,991
53.00	05300	ANESTHESIOLOGY	0	373,168	373,168	-366,705	6,463
54.00	05400	RADIOLOGY-DIAGNOSTIC	543,168	535,995	1,079,163	-16,188	1,062,975
60.00	06000	LABORATORY	614,681	977,697	1,592,378	-3,232	1,589,146
65.00	06500	RESPIRATORY THERAPY	375,642	124,530	500,172	-29,084	471,088
66.00	06600	PHYSICAL THERAPY	527,836	27,482	555,318	-3,391	551,927
69.00	06900	ELECTROCARDIOLOGY	54,664	270,424	325,088	24,652	349,740
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	52,958	-23,465	29,493	248,284	277,777
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	102,579	102,579
73.00	07300	DRUGS CHARGED TO PATIENTS	367,339	538,391	905,730	40,232	945,962
76.00	03550	GERIATRIC PSYCH	238,552	124,984	363,536	-2,644	360,892
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,167,847	227,517	1,395,364	-505,739	889,625
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0
90.01	04951	WOUND CARE	0	120,200	120,200	0	120,200
90.02	09000	CLINIC	804,143	54,214	858,357	-17,423	840,934
91.00	09100	EMERGENCY	694,735	1,065,991	1,760,726	-27,113	1,733,613
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	14,031	14,031
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	589,936	69,117	659,053	342	659,395
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		239,691	239,691	-239,691	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,368,538	15,392,657	25,761,195	-7,476	25,753,719
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	7,476	7,476
192.01	19201	PROMOTION	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
200.00		TOTAL (SUM OF LINES 118 through 199)	10,368,538	15,392,657	25,761,195	0	25,761,195

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet A

Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-142,067	1,035,868	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,795	984,840	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-243	4,314,836	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-39,674	3,295,378	5.00
7.00	00700	OPERATION OF PLANT	0	1,132,909	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,058	8.00
9.00	00900	HOUSEKEEPING	0	362,387	9.00
10.00	01000	DIETARY	0	261,154	10.00
11.00	01100	CAFETERIA	0	258,426	11.00
13.00	01300	NURSING ADMINISTRATION	0	261,731	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,683	284,026	16.00
17.00	01700	SOCIAL SERVICE	0	182,224	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	366,705	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-492,183	1,532,194	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	701,991	50.00
53.00	05300	ANESTHESIOLOGY	0	6,463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,062,975	54.00
60.00	06000	LABORATORY	0	1,589,146	60.00
65.00	06500	RESPIRATORY THERAPY	0	471,088	65.00
66.00	06600	PHYSICAL THERAPY	0	551,927	66.00
69.00	06900	ELECTROCARDIOLOGY	-192,647	157,093	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-1,281	276,496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	102,579	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-12,525	933,437	73.00
76.00	03550	GERIATRIC PSYCH	-1,587	359,305	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-225	889,400	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	90.00
90.01	04951	WOUND CARE	0	120,200	90.01
90.02	09000	CLINIC	-317,325	523,609	90.02
91.00	09100	EMERGENCY	0	1,733,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	14,031	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	14,031	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	659,395	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,205,235	24,548,484	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,476	192.00
192.01	19201	PROMOTION	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,205,235	24,555,960	200.00

RECLASSIFICATIONS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
9/3/2019 12:25 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	239,691		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	239,691		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	153,800	104,626		1.00
	TOTALS		153,800	104,626		
	C - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	122,465		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	122,465		
	D - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	253,401		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	253,401		
	E - DRUGS CHARGED RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	40,232		1.00
2.00	AMBULANCE SERVICES	95.00	0	1,840		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
	TOTALS		0	42,072		
	F - POB REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,476		1.00
	TOTALS		0	7,476		
	G - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	102,579		1.00
	TOTALS		0	102,579		
	I - RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	24,652	0		1.00
	TOTALS		24,652	0		
	K - PROPERTY INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,706		1.00
	TOTALS		0	34,706		
	L - HOSPITALIST					
1.00	ADULTS & PEDIATRICS	30.00	492,183	0		1.00
	TOTALS		492,183	0		
	M - BLOOD TRANSFUSION					
1.00	OTHER OUTPATIENT SERVICE	93.00	14,031	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		14,031	0		
	N - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	366,705		1.00
	TOTALS		0	366,705		
500.00	Grand Total: Increases		684,666	1,273,721		500.00

RECLASSIFICATIONS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-6

Date/Time Prepared:
9/3/2019 12:25 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	239,691	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	239,691			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	153,800	104,626	0		1.00
	TOTALS		153,800	104,626			
	C - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,928	10		1.00
2.00	NURSING ADMINISTRATION	13.00	0	1,123	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,232	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	3,232	0		4.00
5.00	OPERATING ROOM	50.00	0	67,466	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,232	0		6.00
7.00	LABORATORY	60.00	0	3,232	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	4,432	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	3,232	0		9.00
10.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,117	0		10.00
11.00	GERIATRIC PSYCH	76.00	0	2,644	0		11.00
12.00	RURAL HEALTH CLINIC	88.00	0	3,240	0		12.00
13.00	CLINIC	90.02	0	1,545	0		13.00
14.00	EMERGENCY	91.00	0	5,925	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	1,347	0		15.00
16.00	OPERATION OF PLANT	7.00	0	538	0		16.00
	TOTALS		0	122,465			
	D - MED SUPPLIES RECLASS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,645	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	8,320	0		2.00
3.00	OPERATING ROOM	50.00	0	223,286	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	158	0		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	124	0		5.00
6.00	CLINIC	90.02	0	116	0		6.00
7.00	EMERGENCY	91.00	0	19,601	0		7.00
8.00	AMBULANCE SERVICES	95.00	0	151	0		8.00
	TOTALS		0	253,401			
	E - DRUGS CHARGED RECLASS						
1.00	DIETARY	10.00	0	227	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	2,596	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	669	0		3.00
4.00	OPERATING ROOM	50.00	0	1,219	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,311	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	1	0		6.00
7.00	RURAL HEALTH CLINIC	88.00	0	10,192	0		7.00
8.00	CLINIC	90.02	0	15,762	0		8.00
9.00	EMERGENCY	91.00	0	95	0		9.00
	TOTALS		0	42,072			
	F - POB REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,476	0		1.00
	TOTALS		0	7,476			
	G - IMPLANTABLE SUPPLIES						
1.00	OPERATING ROOM	50.00	0	102,579	0		1.00
	TOTALS		0	102,579			
	I - RECLASS EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	24,652	0	0		1.00
	TOTALS		24,652	0			
	K - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,706	12		1.00
	TOTALS		0	34,706			
	L - HOSPITALIST						
1.00	RURAL HEALTH CLINIC	88.00	492,183	0	0		1.00
	TOTALS		492,183	0			
	M - BLOOD TRANSFUSION						
1.00	ADULTS & PEDIATRICS	30.00	12,539	0	0		1.00
2.00	EMERGENCY	91.00	1,492	0	0		2.00
	TOTALS		14,031	0			
	N - CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	366,705	0		1.00
	TOTALS		0	366,705			
500.00	Grand Total: Decreases		684,666	1,273,721			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part I
Date/Time Prepared:
9/3/2019 12:25 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,980	0	0	0	0	1.00	
2.00	Land Improvements	1,075,420	21,342	0	21,342	0	2.00	
3.00	Buildings and Fixtures	16,978,332	95,324	0	95,324	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	7,471,752	689,868	0	689,868	0	6.00	
7.00	HIT designated Assets	424,784	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	26,016,268	806,534	0	806,534	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	26,016,268	806,534	0	806,534	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	65,980	0				1.00	
2.00	Land Improvements	1,096,762	0				2.00	
3.00	Buildings and Fixtures	17,073,656	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,161,620	0				6.00	
7.00	HIT designated Assets	424,784	0				7.00	
8.00	Subtotal (sum of lines 1-7)	26,822,802	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	26,822,802	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part II
Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	901,514	2,024	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	866,170	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,767,684	2,024	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	903,538				1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0				1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	866,170				2.00
3.00	Total (sum of lines 1-2)	0	1,769,708				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet A-7
Part III
Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	18,053,752	-53,822	18,107,574	0.703469	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	7,471,752	-161,073	7,632,825	0.296531	0	2.00
3.00	Total (sum of lines 1-2)	25,525,504	-214,895	25,740,399	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	901,514	2,024	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	862,375	122,465	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,763,889	124,489	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	97,624	34,706	0	0	1,035,868	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	984,840	2.00
3.00	Total (sum of lines 1-2)	97,624	34,706	0	0	2,020,708	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8

Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		-142,067	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)			NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)			NEW CAP REL COSTS-BLDG EKG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,351	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,002,155			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,683	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		RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE			NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG			NEW CAP REL COSTS-BLDG EKG	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant				0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8

Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUITMENT	A	-17,017	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER OPERATING REVENUE	B	-60	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	PHARMACY REBATES	B	-12,525	DRUGS CHARGED TO PATIENTS	73.00	0	35.00
36.00	OTHER REVENUE	B	2,873	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHER REVENUE	B	-788	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PURCHASING REBATES	B	-1,281	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38.00
42.00	LOBBYING EXPENSE	A	-10,415	ADMINISTRATIVE & GENERAL	5.00	0	42.00
44.00	RHC MISC INCOME	B	-225	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	COMMUNITY OUTREACH	A	-1,587	GERIATRIC PSYCH	76.00	0	45.00
45.01	PATIENT TV DEPRECIATION	A	-1,861	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PATIENT PHONE SALARY	A	-896	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PATIENT PHONE BENEFITS	A	-243	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PATIENT PHONE DEPRECIATION	A	-1,934	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.04
45.05	MARKETING EXPENSE	A	-6,020	ADMINISTRATIVE & GENERAL	5.00	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,205,235				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: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet A-8-2

Date/Time Prepared:
9/3/2019 12:25 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	492,183	492,183	0	0	0	1.00
2.00	91.00	EMERGENCY	934,355	0	934,355	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	192,647	192,647	0	0	0	3.00
4.00	90.02	CLINIC	317,325	317,325	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,936,510	1,002,155	934,355		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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.02	CLINIC	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	492,183		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	192,647		3.00
4.00	90.02	CLINIC	0	0	0	317,325		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,002,155		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
		0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,035,868	1,035,868			1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	984,840			984,840	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,314,836	4,792	0	4,265	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,295,378	239,834	0	213,485	5.00
7.00	00700	OPERATION OF PLANT	1,132,909	92,058	0	81,944	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	123,058	19,167	0	17,061	8.00
9.00	00900	HOUSEKEEPING	362,387	7,058	0	6,282	9.00
10.00	01000	DIETARY	261,154	23,074	0	20,539	10.00
11.00	01100	CAFETERIA	258,426	9,654	0	8,594	11.00
13.00	01300	NURSING ADMINISTRATION	261,731	4,013	0	3,572	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	284,026	18,164	0	18,185	16.00
17.00	01700	SOCIAL SERVICE	182,224	2,136	0	1,902	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	366,705	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,532,194	173,636	0	154,559	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	701,991	106,563	0	94,855	50.00
53.00	05300	ANESTHESIOLOGY	6,463	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,062,975	57,796	0	51,446	54.00
60.00	06000	LABORATORY	1,589,146	14,057	0	12,512	60.00
65.00	06500	RESPIRATORY THERAPY	471,088	19,438	0	17,303	65.00
66.00	06600	PHYSICAL THERAPY	551,927	40,919	0	36,423	66.00
69.00	06900	ELECTROCARDIOLOGY	157,093	36,021	0	32,378	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	276,496	16,311	0	14,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,579	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	933,437	6,727	0	5,988	73.00
76.00	03550	GERIATRIC PSYCH	359,305	17,031	0	15,160	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	889,400	21,976	0	61,584	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	90.00
90.01	04951	WOUND CARE	120,200	16,523	0	0	90.01
90.02	09000	CLINIC	523,609	17,704	0	15,758	90.02
91.00	09100	EMERGENCY	1,733,613	69,233	0	61,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	14,031	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	659,395	0	0	33,135	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,548,484	1,033,885	0	983,075	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,983	0	1,765	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,476	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	24,555,960	1,035,868	0	984,840	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,323,893					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	527,629	4,276,326	4,276,326			5.00
7.00	00700	OPERATION OF PLANT	97,592	1,404,503	296,165	1,700,668		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,205	165,491	34,897	46,621	247,009	8.00
9.00	00900	HOUSEKEEPING	123,841	499,568	105,343	17,167	0	9.00
10.00	01000	DIETARY	64,871	369,638	77,945	56,123	203	10.00
11.00	01100	CAFETERIA	64,138	340,812	71,866	23,483	0	11.00
13.00	01300	NURSING ADMINISTRATION	105,291	374,607	78,993	9,761	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,458	414,833	87,475	44,181	0	16.00
17.00	01700	SOCIAL SERVICE	71,251	257,513	54,301	5,196	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	366,705	77,326	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	739,703	2,600,092	548,276	422,347	142,249	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	113,673	1,017,082	214,470	259,201	11,381	50.00
53.00	05300	ANESTHESIOLOGY	0	6,463	1,363	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	226,512	1,398,729	294,947	140,581	22,477	54.00
60.00	06000	LABORATORY	256,335	1,872,050	394,755	34,191	0	60.00
65.00	06500	RESPIRATORY THERAPY	146,370	654,199	137,950	47,281	0	65.00
66.00	06600	PHYSICAL THERAPY	220,119	849,388	179,109	99,529	12,639	66.00
69.00	06900	ELECTROCARDIOLOGY	33,076	258,568	54,524	87,616	4,463	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,085	329,411	69,462	39,674	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	102,579	21,631	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	153,188	1,099,340	231,816	16,363	0	73.00
76.00	03550	GERIATRIC PSYCH	99,481	490,977	103,531	41,425	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	281,766	1,254,726	264,582	53,454	507	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	136,723	28,831	40,191	0	90.01
90.02	09000	CLINIC	335,345	892,416	188,182	43,061	0	90.02
91.00	09100	EMERGENCY	289,097	2,153,569	454,119	168,399	53,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	5,851	19,882	4,192	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	246,016	938,546	197,909	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,323,893	24,544,736	4,273,960	1,695,845	247,009	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,748	790	4,823	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,476	1,576	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,323,893	24,555,960	4,276,326	1,700,668	247,009	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

Period:
From 04/01/2018
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	622,078					9.00
10.00	01000	DIETARY	49,175	553,084				10.00
11.00	01100	CAFETERIA	0	231,430	667,591			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	22,351	485,712		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,818	0	36,235	0	595,542	16.00
17.00	01700	SOCIAL SERVICE	0	0	11,288	21,354	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,852	255,714	140,711	263,708	391,816	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,440	0	26,358	49,659	27,004	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,993	0	62,255	0	57,918	54.00
60.00	06000	LABORATORY	37,002	0	86,694	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	40,845	0	41,597	0	0	65.00
66.00	06600	PHYSICAL THERAPY	24,722	0	43,968	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,182	0	6,039	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,232	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,369	0	26,528	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	26,217	23,649	40,291	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	90,853	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09000	CLINIC	0	0	55,369	0	0	90.02
91.00	09100	EMERGENCY	175,848	0	72,753	110,700	118,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	553,099	513,361	667,027	485,712	595,542	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	68,979	39,723	564	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	622,078	553,084	667,591	485,712	595,542	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1323

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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	349,652					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	444,031				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	349,652	0	5,149,417	0	5,149,417	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	444,031	2,052,626	0	2,052,626	50.00
53.00	05300	ANESTHESIOLOGY	0	0	7,826	0	7,826	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,052,900	0	2,052,900	54.00
60.00	06000	LABORATORY	0	0	2,424,692	0	2,424,692	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	921,872	0	921,872	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,209,355	0	1,209,355	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	412,392	0	412,392	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	449,779	0	449,779	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	124,210	0	124,210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,380,416	0	1,380,416	73.00
76.00	03550	GERIATRIC PSYCH	0	0	726,090	0	726,090	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	1,664,122	0	1,664,122	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	205,745	0	205,745	90.01
90.02	09000	CLINIC	0	0	1,179,028	0	1,179,028	90.02
91.00	09100	EMERGENCY	0	0	3,307,282	0	3,307,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	24,074	0	24,074	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	1,136,455	0	1,136,455	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	349,652	444,031	24,428,281	0	24,428,281	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	9,361	0	9,361	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	118,318	0	118,318	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	349,652	444,031	24,555,960	0	24,555,960	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,792	0	0	4,265	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	239,834	0	0	213,485	5.00
7.00	00700	OPERATION OF PLANT	0	92,058	0	0	81,944	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,167	0	0	17,061	8.00
9.00	00900	HOUSEKEEPING	0	7,058	0	0	6,282	9.00
10.00	01000	DIETARY	0	23,074	0	0	20,539	10.00
11.00	01100	CAFETERIA	0	9,654	0	0	8,594	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,013	0	0	3,572	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,164	0	0	18,185	16.00
17.00	01700	SOCIAL SERVICE	0	2,136	0	0	1,902	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	173,636	0	0	154,559	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	106,563	0	0	94,855	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,796	0	0	51,446	54.00
60.00	06000	LABORATORY	0	14,057	0	0	12,512	60.00
65.00	06500	RESPIRATORY THERAPY	0	19,438	0	0	17,303	65.00
66.00	06600	PHYSICAL THERAPY	0	40,919	0	0	36,423	66.00
69.00	06900	ELECTROCARDIOLOGY	0	36,021	0	0	32,378	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	16,311	0	0	14,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,727	0	0	5,988	73.00
76.00	03550	GERIATRIC PSYCH	0	17,031	0	0	15,160	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	21,976	0	0	61,584	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	16,523	0	0	0	90.01
90.02	09000	CLINIC	0	17,704	0	0	15,758	90.02
91.00	09100	EMERGENCY	0	69,233	0	0	61,626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	33,135	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,033,885	0	0	983,075	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,983	0	0	1,765	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,035,868	0	0	984,840	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
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Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,057	9,057				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	453,319	1,106	454,425			5.00
7.00	00700	OPERATION OF PLANT	174,002	205	31,472	205,679		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,228	13	3,708	5,638	45,587	8.00
9.00	00900	HOUSEKEEPING	13,340	260	11,194	2,076	0	9.00
10.00	01000	DIETARY	43,613	136	8,283	6,788	37	10.00
11.00	01100	CAFETERIA	18,248	134	7,637	2,840	0	11.00
13.00	01300	NURSING ADMINISTRATION	7,585	221	8,394	1,180	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,349	198	9,296	5,343	0	16.00
17.00	01700	SOCIAL SERVICE	4,038	149	5,770	628	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	8,217	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	328,195	1,545	58,261	51,080	26,253	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	201,418	238	22,791	31,348	2,100	50.00
53.00	05300	ANESTHESIOLOGY	0	0	145	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	109,242	475	31,343	17,002	4,148	54.00
60.00	06000	LABORATORY	26,569	537	41,949	4,135	0	60.00
65.00	06500	RESPIRATORY THERAPY	36,741	307	14,659	5,718	0	65.00
66.00	06600	PHYSICAL THERAPY	77,342	461	19,033	12,037	2,333	66.00
69.00	06900	ELECTROCARDIOLOGY	68,399	69	5,794	10,596	824	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,830	46	7,381	4,798	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,299	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,715	321	24,634	1,979	0	73.00
76.00	03550	GERIATRIC PSYCH	32,191	208	11,002	5,010	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	83,560	591	28,116	6,465	94	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	16,523	0	3,064	4,861	0	90.01
90.02	09000	CLINIC	33,462	703	19,997	5,208	0	90.02
91.00	09100	EMERGENCY	130,859	606	48,257	20,366	9,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	12	446	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	33,135	516	21,031	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,016,960	9,057	454,173	205,096	45,587	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,748	0	84	583	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	168	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,020,708	9,057	454,425	205,679	45,587	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	26,870					9.00
10.00	01000	DIETARY	2,124	60,981				10.00
11.00	01100	CAFETERIA	0	25,517	54,376			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,821	19,201		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	554	0	2,951	0	54,691	16.00
17.00	01700	SOCIAL SERVICE	0	0	919	844	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,505	28,193	11,461	10,425	35,982	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	149	0	2,147	1,963	2,480	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,282	0	5,071	0	5,319	54.00
60.00	06000	LABORATORY	1,598	0	7,061	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,764	0	3,388	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,068	0	3,581	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	51	0	492	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	915	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	275	0	2,161	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	2,891	1,926	1,593	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	3,924	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09000	CLINIC	0	0	4,510	0	0	90.02
91.00	09100	EMERGENCY	7,597	0	5,926	4,376	10,910	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,891	56,601	54,330	19,201	54,691	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,979	4,380	46	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	26,870	60,981	54,376	19,201	54,691	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	12,348					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	8,217				19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,348		565,248	0	565,248	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		264,634	0	264,634	50.00
53.00	05300	ANESTHESIOLOGY	0		145	0	145	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		175,882	0	175,882	54.00
60.00	06000	LABORATORY	0		81,849	0	81,849	60.00
65.00	06500	RESPIRATORY THERAPY	0		62,577	0	62,577	65.00
66.00	06600	PHYSICAL THERAPY	0		115,855	0	115,855	66.00
69.00	06900	ELECTROCARDIOLOGY	0		86,225	0	86,225	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		43,970	0	43,970	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		2,299	0	2,299	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		42,085	0	42,085	73.00
76.00	03550	GERIATRIC PSYCH	0		54,821	0	54,821	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		122,750	0	122,750	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.00
90.01	04951	WOUND CARE	0		24,448	0	24,448	90.01
90.02	09000	CLINIC	0		63,880	0	63,880	90.02
91.00	09100	EMERGENCY	0		238,695	0	238,695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0		458	0	458	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		54,682	0	54,682	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,348	0	2,000,503	0	2,000,503	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		4,415	0	4,415	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		7,573	0	7,573	192.00
192.01	19201	PROMOTION	0		0	0	0	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
200.00		Cross Foot Adjustments		8,217	8,217	0	8,217	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,348	8,217	2,020,708	0	2,020,708	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)		
			1.00	1.01	1.02	2.00	4.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	87,768					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	0			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				93,744		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	406	0	0	406	10,368,538	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,321	0	0	20,321	1,265,234	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	234,021	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	14,879	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	296,965	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	155,559	10.00
11.00	01100	CAFETERIA	818	0	0	818	153,800	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	252,483	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	0	1,731	226,506	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	170,856	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	1,773,795	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	272,583	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	543,168	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	614,681	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	350,990	65.00
66.00	06600	PHYSICAL THERAPY	3,467	0	0	3,467	527,836	66.00
69.00	06900	ELECTROCARDIOLOGY	3,052	0	0	3,082	79,316	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,382	0	0	1,382	52,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	367,339	73.00
76.00	03550	GERIATRIC PSYCH	1,443	0	0	1,443	238,552	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,862	0	0	5,862	675,664	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	1,400	0	0	0	0	90.01
90.02	09000	CLINIC	1,500	0	0	1,500	804,143	90.02
91.00	09100	EMERGENCY	5,866	0	0	5,866	693,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	14,031	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	3,154	589,936	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	87,600	0	0	93,576	10,368,538	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,035,868	0	0	984,840	4,323,893	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.802343	0.000000	0.000000	10.505632	0.417021	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					9,057	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000874	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: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
			5A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,276,326	20,279,634				5.00
7.00	00700	OPERATION OF PLANT	0	1,404,503	59,241			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	165,491	1,624	12,176		8.00
9.00	00900	HOUSEKEEPING	0	499,568	598	0	115,750	9.00
10.00	01000	DIETARY	0	369,638	1,955	10	9,150	10.00
11.00	01100	CAFETERIA	0	340,812	818	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	374,607	340	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	414,833	1,539	0	2,385	16.00
17.00	01700	SOCIAL SERVICE	0	257,513	181	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	366,705	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,600,092	14,712	7,012	6,485	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,017,082	9,029	561	640	50.00
53.00	05300	ANESTHESIOLOGY	0	6,463	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,398,729	4,897	1,108	14,140	54.00
60.00	06000	LABORATORY	0	1,872,050	1,191	0	6,885	60.00
65.00	06500	RESPIRATORY THERAPY	0	654,199	1,647	0	7,600	65.00
66.00	06600	PHYSICAL THERAPY	0	849,388	3,467	623	4,600	66.00
69.00	06900	ELECTROCARDIOLOGY	0	258,568	3,052	220	220	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	329,411	1,382	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	102,579	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,099,340	570	0	1,185	73.00
76.00	03550	GERIATRIC PSYCH	0	490,977	1,443	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,254,726	1,862	25	16,905	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	136,723	1,400	0	0	90.01
90.02	09000	CLINIC	0	892,416	1,500	0	0	90.02
91.00	09100	EMERGENCY	0	2,153,569	5,866	2,617	32,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	19,882	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	938,546	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,276,326	20,268,410	59,073	12,176	102,915	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,748	168	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,476	0	0	12,835	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		4,276,326	1,700,668	247,009	622,078	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.210868	28.707618	20.286547	5.374324	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		454,425	205,679	45,587	26,870	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.022408	3.471903	3.744005	0.232138	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: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNED TI MES)	
			10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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	42,341					10.00
11.00	01100	CAFETERIA	17,717	11,828				11.00
13.00	01300	NURSING ADMINISTRATION	0	396	4,822			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	642	0	205,650		16.00
17.00	01700	SOCIAL SERVICE	0	200	212	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,576	2,493	2,618	135,300	100	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	467	493	9,325	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,103	0	20,000	0	54.00
60.00	06000	LABORATORY	0	1,536	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	737	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	779	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	107	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	199	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	470	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	2,007	419	400	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09000	CLINIC	0	981	0	0	0	90.02
91.00	09100	EMERGENCY	0	1,289	1,099	41,025	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	39,300	11,818	4,822	205,650	100	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,041	10	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	553,084	667,591	485,712	595,542	349,652	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.062611	56.441579	100.728328	2.895901	3,496.520000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	60,981	54,376	19,201	54,691	12,348	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.440235	4.597227	3.981958	0.265942	123.480000	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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet B-1
Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		19.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	1.02
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
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
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	GERIATRIC PSYCH	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	90.00
90.01	04951	WOUND CARE	90.01
90.02	09000	CLINIC	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	93.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	PROMOTION	192.01
193.00	19300	NONPAID WORKERS	193.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet B-2

Date/Time Prepared:
9/3/2019 12:25 am

		Description	Worksheet		Amount	
			CODE	Line No.		
			1.00	2.00	3.00	4.00
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS		1	74.00	0 1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM		1	94.00	0 2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS		1	74.00	0 3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM		1	94.00	0 4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS		1	74.00	0 5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM		1	94.00	0 6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
9/3/2019 12:25 am

			Title XVIII		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,149,417		5,149,417	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,052,626		2,052,626	0	0	50.00
53.00	05300	ANESTHESIOLOGY	7,826		7,826	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,052,900		2,052,900	0	0	54.00
60.00	06000	LABORATORY	2,424,692		2,424,692	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	921,872	0	921,872	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,209,355	0	1,209,355	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	412,392		412,392	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	449,779		449,779	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	124,210		124,210	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,380,416		1,380,416	0	0	73.00
76.00	03550	GERIATRIC PSYCH	726,090		726,090	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,664,122		1,664,122	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	90.00
90.01	04951	WOUND CARE	205,745		205,745	0	0	90.01
90.02	09000	CLINIC	1,179,028		1,179,028	0	0	90.02
91.00	09100	EMERGENCY	3,307,282		3,307,282	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	428,337		428,337	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	24,074		24,074	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,136,455		1,136,455	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,856,618	0	24,856,618	0	0	200.00
201.00		Less Observation Beds	428,337		428,337			201.00
202.00		Total (see instructions)	24,428,281	0	24,428,281	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
9/3/2019 12:25 am

			Title XVIII		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,102,481		3,102,481			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	4,216,699	4,216,699	0.486785	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	764,520	764,520	0.010236	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,265,831	15,669,824	18,935,655	0.108415	0.000000	54.00
60.00	06000	LABORATORY	1,857,412	4,984,605	6,842,017	0.354383	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,495,489	295,410	1,790,899	0.514754	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	397,781	1,171,135	1,568,916	0.770822	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	802,213	2,335,999	3,138,212	0.131410	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,361	49,120	62,481	7.198652	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	153,867	153,867	0.807256	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,435,613	1,090,404	2,526,017	0.546479	0.000000	73.00
76.00	03550	GERIATRIC PSYCH	2,671	894,437	897,108	0.809367	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	552,565	552,565			88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	90.00
90.01	04951	WOUND CARE	0	288,363	288,363	0.713493	0.000000	90.01
90.02	09000	CLINIC	0	591,359	591,359	1.993760	0.000000	90.02
91.00	09100	EMERGENCY	726,153	4,543,925	5,270,078	0.627558	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,523	197,127	202,650	2.113679	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	64,567	64,567	0.372853	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,046,877	2,046,877	0.555214	0.000000	95.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,104,528	39,910,803	53,015,331			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,104,528	39,910,803	53,015,331			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet C
Part I
Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 GERIATRIC PSYCH	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000			90.00
90.01	04951 WOUND CARE	0.000000			90.01
90.02	09000 CLINIC	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part II
Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	264,634	4,216,699	0.062759	0	0	50.00
53.00	05300 ANESTHESIOLOGY	145	764,520	0.000190	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	175,882	18,935,655	0.009288	1,128,547	10,482	54.00
60.00	06000 LABORATORY	81,849	6,842,017	0.011963	988,818	11,829	60.00
65.00	06500 RESPIRATORY THERAPY	62,577	1,790,899	0.034942	791,242	27,648	65.00
66.00	06600 PHYSICAL THERAPY	115,855	1,568,916	0.073844	130,589	9,643	66.00
69.00	06900 ELECTROCARDIOLOGY	86,225	3,138,212	0.027476	407,389	11,193	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	43,970	62,481	0.703734	6,036	4,248	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,299	153,867	0.014941	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	42,085	2,526,017	0.016661	881,569	14,688	73.00
76.00	03550 GERIATRIC PSYCH	54,821	897,108	0.061109	2,671	163	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	122,750	552,565	0.222146	0	0	88.00
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	90.00
90.01	04951 WOUND CARE	24,448	288,363	0.084782	0	0	90.01
90.02	09000 CLINIC	63,880	591,359	0.108022	0	0	90.02
91.00	09100 EMERGENCY	238,695	5,270,078	0.045292	5,465	248	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	47,018	202,650	0.232016	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	458	64,567	0.007093	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	1,427,591	47,865,973		4,342,326	90,142	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-1323		Period: From 04/01/2018 To 03/31/2019		Worksheet D Part IV Date/Time Prepared: 9/3/2019 12:25 am	
			Title XVIII		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	444,031	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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	90.00
90.01	04951	WOUND CARE	0	0	0	0	0	90.01
90.02	09000	CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	444,031	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
9/3/2019 12:25 am

				Title XVIII		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	444,031	0	4,216,699	0.105303	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	764,520	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	18,935,655	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	6,842,017	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,790,899	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,568,916	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,138,212	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	62,481	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	153,867	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,526,017	0.000000	73.00
76.00	03550	GERIATRIC PSYCH	0	0	0	897,108	0.000000	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	552,565	0.000000	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	90.00
90.01	04951	WOUND CARE	0	0	0	288,363	0.000000	90.01
90.02	09000	CLINIC	0	0	0	591,359	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	5,270,078	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	202,650	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0	0	64,567	0.000000	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	444,031	0	47,865,973		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part IV
Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,128,547	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	988,818	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	791,242	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	130,589	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	407,389	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,036	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	881,569	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0.000000	2,671	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.000000	0	0	0	0	90.01
90.02	09000	CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	5,465	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.000000	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		4,342,326	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
9/3/2019 12:25 am

			Title XVIII		Hospital		Cost	
	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00			
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.486785	0	1,740,905	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.010236	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108415	0	6,321,497	0	0	54.00
60.00	06000	LABORATORY	0.354383	0	1,867,168	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.514754	0	77,487	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.770822	0	454,342	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.131410	0	981,470	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7.198652	0	26,363	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.807256	0	134,083	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.546479	0	649,547	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0.809367	0	726,919	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.713493	0	118,313	0	0	90.01
90.02	09000	CLINIC	1.993760	0	232,310	0	0	90.02
91.00	09100	EMERGENCY	0.627558	0	1,490,655	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.113679	0	36,767	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.372853	0	60,000	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.555214		0			95.00
200.00		Subtotal (see instructions)		0	14,917,826	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	14,917,826	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet D
Part V
Date/Time Prepared:
9/3/2019 12:25 am

			Title XVIII		Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	847,446	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	685,345	0		54.00
60.00	06000	LABORATORY	661,693	0		60.00
65.00	06500	RESPIRATORY THERAPY	39,887	0		65.00
66.00	06600	PHYSICAL THERAPY	350,217	0		66.00
69.00	06900	ELECTROCARDIOLOGY	128,975	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	189,778	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	108,239	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	354,964	0		73.00
76.00	03550	GERIATRIC PSYCH	588,344	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	84,415	0		90.01
90.02	09000	CLINIC	463,170	0		90.02
91.00	09100	EMERGENCY	935,472	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	77,714	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	22,371	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,538,030	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	5,538,030	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2018
To 03/31/2019Part V
Date/Time Prepared:
9/3/2019 12:25 am

			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.486785	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.010236	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108415	0	0	0	0	54.00
60.00	06000	LABORATORY	0.354383	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.514754	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.770822	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.131410	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7.198652	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.807256	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.546479	0	0	0	0	73.00
76.00	03550	GERIATRIC PSYCH	0.809367	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	90.00
90.01	04951	WOUND CARE	0.713493	0	0	0	0	90.01
90.02	09000	CLINIC	1.993760	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.627558	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2.113679	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0.372853	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.555214		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1323

Period:

Worksheet D

Component CCN: 14-Z323

From 04/01/2018
To 03/31/2019Part V
Date/Time Prepared:
9/3/2019 12:25 am

			Title XVIII		Swing Beds - SNF	Cost
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	GERIATRIC PSYCH	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		90.00
90.01	04951	WOUND CARE	0	0		90.01
90.02	09000	CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE	0	0		93.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet D-1 Date/Time Prepared: 9/3/2019 12:25 am	
		Title XVIII	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,016	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,252	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)			2,930	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			243	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)			360	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			85	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)			76	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			2,147	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			243	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)			360	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			132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)			5,149,417	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)			11,272	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)			10,078	25.00
26.00	Total swing-bed cost (see instructions)			823,485	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,325,932	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)			4,325,932	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,330.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,856,025	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)			2,856,025	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		Title XVIII		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,565,064	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,421,089	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)					323,248	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					478,886	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					802,134	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)					322	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,330.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					428,337	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet D-1

Date/Time Prepared:
9/3/2019 12:25 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	565,248	5,149,417	0.109769	428,337	47,018
91.00	Nursing School cost	0	5,149,417	0.000000	428,337	0
92.00	Allied health cost	0	5,149,417	0.000000	428,337	0
93.00	All other Medical Education	0	5,149,417	0.000000	428,337	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 9/3/2019 12:25 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,645,990		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.486785	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.010236	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.108415	1,128,547	122,351	54.00
60.00	06000 LABORATORY	0.354383	988,818	350,420	60.00
65.00	06500 RESPIRATORY THERAPY	0.514754	791,242	407,295	65.00
66.00	06600 PHYSICAL THERAPY	0.770822	130,589	100,661	66.00
69.00	06900 ELECTROCARDIOLOGY	0.131410	407,389	53,535	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7.198652	6,036	43,451	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.807256	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.546479	881,569	481,759	73.00
76.00	03550 GERIATRIC PSYCH	0.809367	2,671	2,162	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.00
90.01	04951 WOUND CARE	0.713493	0	0	90.01
90.02	09000 CLINIC	1.993760	0	0	90.02
91.00	09100 EMERGENCY	0.627558	5,465	3,430	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.113679	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.372853	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,342,326	1,565,064	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		4,342,326		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1323 Component CCN: 14-Z323	Period: From 04/01/2018 To 03/31/2019	Worksheet D-3 Date/Time Prepared: 9/3/2019 12:25 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		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	0.486785	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.010236	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.108415	75,960	8,235	54.00
60.00	06000 LABORATORY	0.354383	112,128	39,736	60.00
65.00	06500 RESPIRATORY THERAPY	0.514754	189,555	97,574	65.00
66.00	06600 PHYSICAL THERAPY	0.770822	153,063	117,984	66.00
69.00	06900 ELECTROCARDIOLOGY	0.131410	13,029	1,712	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7.198652	1,705	12,274	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.807256	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.546479	193,456	105,720	73.00
76.00	03550 GERIATRIC PSYCH	0.809367	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	90.00
90.01	04951 WOUND CARE	0.713493	0	0	90.01
90.02	09000 CLINIC	1.993760	0	0	90.02
91.00	09100 EMERGENCY	0.627558	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2.113679	0	0	92.00
93.00	04040 OTHER OUTPATIENT SERVICE	0.372853	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		738,896	383,235	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)		738,896		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet E Part B Date/Time Prepared: 9/3/2019 12:25 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,538,030	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,538,030	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,593,410	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)		51,834	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,573,748	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)		2,967,828	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)		2,967,828	30.00
31.00	Primary payer payments		29	31.00
32.00	Subtotal (line 30 minus line 31)		2,967,799	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)		772,544	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		502,154	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		571,289	36.00
37.00	Subtotal (see instructions)		3,469,953	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,469,953	40.00
40.01	Sequestration adjustment (see instructions)		69,399	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,357,465	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1,043,089	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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet E-1
Part I
Date/Time Prepared:
9/3/2019 12:25 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,105,013		2,538,930	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	11/13/2018	343,945		0	3.01
3.02		03/27/2018	149,652		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	10/31/2018	575,449	10/31/2018	166,590	3.50
3.51		03/29/2019	25,920	11/13/2018	5,863	3.51
3.52			0	03/29/2019	9,012	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)		-107,772		-181,465	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)		3,997,241		2,357,465	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		21,213		1,043,089	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,018,454		3,400,554	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	CGS		15101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1323

Period:

Worksheet E-1

Component CCN: 14-Z323

From 04/01/2018
To 03/31/2019Part I
Date/Time Prepared:
9/3/2019 12:25 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,240,266		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	11/13/2018	58,224		0	3.01
3.02		03/29/2019	23,763		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)		81,987		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,322,253		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		160,967		0	6.02
7.00	Total Medicare program liability (see instructions)		1,161,286		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	CGS		15101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet E-1
Part II
Date/Time Prepared:
9/3/2019 12:25 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 14-1323

Period:

Worksheet E-2

Component CCN: 14-Z323

From 04/01/2018
To 03/31/2019Date/Time Prepared:
9/3/2019 12:25 am

		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		810,155	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)		387,067	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		603	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1,197,222	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,197,222	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		1,197,222	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		12,236	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1,184,986	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		1,184,986	0	19.00
19.01	Sequestration adjustment (see instructions)		23,700	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
20.00	Interim payments		1,322,253	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)		-160,967	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: 14-1323	Period: From 04/01/2018 To 03/31/2019	Worksheet E-3 Part V Date/Time Prepared: 9/3/2019 12:25 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		4,421,089	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)		4,421,089	4.00
5.00	Primary payer payments		7,514	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		4,457,786	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)		4,457,786	19.00
20.00	Deductibles (exclude professional component)		515,120	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		3,942,666	22.00
23.00	Coinsurance		13,065	23.00
24.00	Subtotal (line 22 minus line 23)		3,929,601	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		262,864	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		170,862	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		216,918	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		4,100,463	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)		4,100,463	30.00
30.01	Sequestration adjustment (see instructions)		82,009	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
31.00	Interim payments		3,997,241	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)		21,213	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: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet G

Date/Time Prepared:
9/3/2019 12:25 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	18,087,795	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	8,779,464	0	0	0	4.00
5.00	Other receivable	221,652	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,920,644	0	0	0	6.00
7.00	Inventory	355,785	0	0	0	7.00
8.00	Prepaid expenses	466,215	0	0	0	8.00
9.00	Other current assets	39,151	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)	23,029,418	0	0	0	11.00
FIXED ASSETS						
12.00	Land	65,980	0	0	0	12.00
13.00	Land improvements	1,103,982	0	0	0	13.00
14.00	Accumulated depreciation	-881,873	0	0	0	14.00
15.00	Buildings	17,370,221	0	0	0	15.00
16.00	Accumulated depreciation	-9,207,103	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,134,659	0	0	0	23.00
24.00	Accumulated depreciation	-7,764,741	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	651,543	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,472,668	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	140,943	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	140,943	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,643,029	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	567,320	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,407,651	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	802,234	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,777,205	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,349,669	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	907,238	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,256,907	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,034,112	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	22,608,917				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)	22,608,917	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,643,029	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet G-1

Date/Time Prepared:
9/3/2019 12:25 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		21,689,924		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,993				2.00
3.00	Total (sum of line 1 and line 2)		21,700,917		0		3.00
4.00	NON OPERATING EQUITY ADJ	908,000		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)		908,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,608,917		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)		22,608,917		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	NON OPERATING EQUITY ADJ		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: 14-1323

Period:
From 04/01/2018
To 03/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
9/3/2019 12:25 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,154,014		3,154,014	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	844,419		844,419	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,998,433		3,998,433	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)	3,998,433		3,998,433	17.00
18.00	Ancillary services	9,965,668	37,350,854	47,316,522	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	548,436	548,436	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,038,789	2,038,789	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	13,964,101	39,938,079	53,902,180	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		25,761,195		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	OTHER	299,565			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)		299,565		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,461,630		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1323

Period:
From 04/01/2018
To 03/31/2019

Worksheet G-3

Date/Time Prepared:
9/3/2019 12:25 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	53,902,180	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,350,854	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,551,326	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,461,630	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-910,304	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	109,518	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	811,779	24.00
25.00	Total other income (sum of lines 6-24)	921,297	25.00
26.00	Total (line 5 plus line 25)	10,993	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,993	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-3478

From 04/01/2018
To 03/31/2019

Date/Time Prepared:

9/3/2019 12:25 am

		RHC I		Cost	
	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS					
1.00 Physician	455,235	0	455,235	0	455,235
2.00 Physician Assistant	0	0	0	0	0
3.00 Nurse Practitioner	47,943	0	47,943	0	47,943
4.00 Visiting Nurse	0	0	0	0	0
5.00 Other Nurse	0	0	0	0	0
6.00 Clinical Psychologist	0	0	0	0	0
7.00 Clinical Social Worker	0	0	0	0	0
8.00 Laboratory Technician	0	0	0	0	0
9.00 Other Facility Health Care Staff Costs	0	0	0	0	0
10.00 Subtotal (sum of lines 1 through 9)	503,178	0	503,178	0	503,178
11.00 Physician Services Under Agreement	0	163,944	163,944	0	163,944
12.00 Physician Supervision Under Agreement	0	0	0	0	0
13.00 Other Costs Under Agreement	0	0	0	0	0
14.00 Subtotal (sum of lines 11 through 13)	0	163,944	163,944	0	163,944
15.00 Medical Supplies	0	6,842	6,842	0	6,842
16.00 Transportation (Health Care Staff)	0	0	0	0	0
17.00 Depreciation-Medical Equipment	0	0	0	0	0
18.00 Professional Liability Insurance	0	0	0	0	0
19.00 Other Health Care Costs	0	0	0	0	0
20.00 Allowable GME Costs	0	0	0	0	0
21.00 Subtotal (sum of lines 15 through 20)	0	6,842	6,842	0	6,842
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	503,178	170,786	673,964	0	673,964
COSTS OTHER THAN RHC/FQHC SERVICES					
23.00 Pharmacy	0	0	0	0	0
24.00 Dental	0	0	0	0	0
25.00 Optometry	0	0	0	0	0
25.01 Telehealth	0	0	0	0	0
25.02 Chronic Care Management	0	0	0	0	0
26.00 All other nonreimbursable costs	0	0	0	0	0
27.00 Nonallowable GME costs	0	0	0	0	0
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD					
29.00 Facility Costs	0	2,936	2,936	0	2,936
30.00 Administrative Costs	183,195	29,305	212,500	0	212,500
31.00 Total Facility Overhead (sum of lines 29 and 30)	183,195	32,241	215,436	0	215,436
32.00 Total facility costs (sum of lines 22, 28 and 31)	686,373	203,027	889,400	0	889,400

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1323

Period:

Worksheet M-1

Component CCN: 14-3478

From 04/01/2018
To 03/31/2019Date/Time Prepared:
9/3/2019 12:25 am

				RHC I	Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	455,235		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	47,943		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	503,178		10.00
11.00	Physician Services Under Agreement	0	163,944		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	163,944		14.00
15.00	Medical Supplies	0	6,842		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	6,842		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	673,964		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	2,936		29.00
30.00	Administrative Costs	0	212,500		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	215,436		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	889,400		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1323

Period:

Worksheet M-2

Component CCN: 14-3478

From 04/01/2018
To 03/31/2019Date/Time Prepared:
9/3/2019 12:25 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY							
Positions							
1.00	Physician	1.99	6,778	4,200	8,358		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.95	3,156	2,100	1,995		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.94	9,934		10,353	10,353	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)	2.94	9,934			10,353	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)					673,964	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)					673,964	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)					215,436	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					774,722	15.00
16.00	Total overhead (sum of lines 14 and 15)					990,158	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					990,158	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					990,158	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,664,122	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2018 To 03/31/2019	Worksheet M-3 Date/Time Prepared: 9/3/2019 12:25 am	
		Title XVIII	RHC I	Cost	
				1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1,664,122	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			8,889	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,655,233	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			10,353	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)			10,353	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			159.88	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		83.45	0.00	8.00
9.00	Rate for Program covered visits (see instructions)		159.88	159.88	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		0	2,296	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	367,084	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	367,084	16.00
16.01	Total program charges (see instructions)(from contractor's records)			165,120	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			277,666	16.04
16.05	Total program cost (see instructions)		0	277,666	16.05
17.00	Primary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			20,002	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			29,020	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			277,666	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			3,368	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			281,034	22.00
23.00	Allowable bad debts (see instructions)			17,755	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			11,541	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			17,178	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)			292,575	26.00
26.01	Sequestration adjustment (see instructions)			5,852	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			285,358	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			1,365	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: 14-1323 Component CCN: 14-3478	Period: From 04/01/2018 To 03/31/2019	Worksheet M-4 Date/Time Prepared: 9/3/2019 12:25 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		503,178	503,178	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001200	0.005500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		604	2,767	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		182	47	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		786	2,814	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		673,964	673,964	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		990,158	990,158	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.001166	0.004175	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		1,155	4,134	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		1,941	6,948	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		30	117	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		64.70	59.38	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		8	48	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		518	2,850	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)			8,889	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)			3,368	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1323 Component CCN: 14-3478	Period: From 04/01/2018 To 03/31/2019	Worksheet M-5 Date/Time Prepared: 9/3/2019 12:25 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		245,933	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		10/31/2018	33,408	3.01	
3.02		03/29/2019	6,017	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)		39,425	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		285,358	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		1,365	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		286,723	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00		
		15101	2.00		
8.00	Name of Contractor	CGS			8.00